MODULE ON THREE-DAY TRAINING

of

PRIMARY HEALTH CENTRE MEDICAL OFFICERS

on

GENDER AND RH

with

FACILITATOR'S MANUAL

UNFPA
United Nations
Population Fund
India

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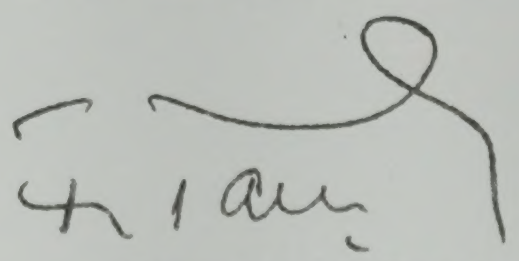
Preface

The objective of this training module on gender and Reproductive Health for Medical Officers is to give a basic exposure to medical personnel on gender issues with a focus on health, especially reproductive health. The aim of formulating this module is to ensure that the ICPD goals with reference to gender equity and equality are achieved and the importance of reproductive rights understood as an integral part of service provision towards improved reproductive health. The RH programmes in the country have been implemented on the assumption that the providers are conscious of socio-cultural and economic inequalities that inhibit women from accessing freely efficient and quality services. A few providers have so far appreciated the practical and strategic needs of women and have understood how sex, which is biologically defined, and gender, which is a socio-cultural construct, interact to disadvantage women, especially in accessing RH/health care. The initial parts of the modules give a conceptual understanding of gender and show how it informs reproductive health. The application of the gender equality concept is explained in the subsequent sections relating to gender-based violence, male participation and practice of gender-sensitive health services and care.

The training methodologies lend themselves to an interactive, participatory and experiential learning based on the experience of participants as women and men in their respective cultural context. The articulation on gender in providing training finds concrete applications and is likely, therefore to be more convincing. The training methodology is based on the promise that participants are the critical resource and the trainer is the facilitator. Any trainer on health with an open mind, a basic human sensitivity and with a good capacity to communicate has the potential to handle these modules as a gender trainer.

The methodologies and design used in these modules are based on the hands-on experience which UNFPA gained conducting a series of stand alone gender trainings in a number of states, during the last one year. Some of the methodologies used by the trainers which were found effective during these trainings, have been used in these modules. UNFPA takes this opportunity to acknowledge the contribution made by Dr. Abhijit Das in enriching these modules.

We wish to acknowledge the contribution of the UNFPA Advisor on Gender, Ms. B. Bhamathi, in putting together this module. Any feedback on the module would be most welcome.



February 2002

Francois M. Farah
UNFPA Representative

SECTION ONE

Setting the Agenda

Preparing to Facilitate a Gender and RH Workshop

GENDER AND REPRODUCTIVE HEALTH – ESTABLISHING THE ESSENTIAL LINKAGE

The Context

Women's health, particularly maternal health, has long been on the agenda of nations, particularly India. Despite intensified efforts at improving maternal health and providing family planning services, women's health in India remains poor. Unacceptably high maternal mortality rates (MMR), pressure on * contributing to a lack of national concern for women's reproductive health problems resulted in the formulation of special programmes that focussed on the special health needs of women. The International Conference on Population and Development (Cairo, 1994) and subsequently the Fourth World Conference on Women (Beijing 1995), firmly established the importance of gender as a critical dimension of women's reproductive health. India, being a signatory to both these conferences, initiated changes in its approach to the family welfare programme in a phased manner. It adopted a target-free approach in April 1996, and began reorientation of its the family welfare programme acording to the Reproductive and Child Health (RCH) approach in October 1997. Subsequently, India issued the National Population Policy in March 2000.

The Problem

For long, it was widely believed that focussing on contraception would lead to a substantial reduction in MMR. Unfortunately, the evidence was to the contrary. While some countries like China reduced maternal mortality figures (MMR 115) and also had a high contraceptive prevalence rate (83%), others showed no such correlation, such as Malaysia (MMR – 20 and CPR 51%)[1] . On the other hand, it was getting increasingly clear that maternal deaths could not serve as the only significant indicator of women's health. Studies from India and elsewhere established the widespread nature of reproductive tract infections, abortion-related infections, cervical cancer, etc. as significant health problems of women. The emergence of HIV/AIDS and the growing understanding of the linkage between health and violence enlarged the very understanding of reproductive health.

The narrow focus on maternal health and contraception in national policies and programmes was also linked to an approach in which health was viewed purely in biological and medical terms. Investigation of women's illness-related behaviour slowly revealed that women's health status is not just a linear outcome of her biological-physiological-pathological status,

[1] UNICEF – The State of the World's Children –(1995)

but includes a complex interplay of economic, social, cultural and religious factors. Among these factors, gender or inequality between men and women, which is socially and culturally defined, is very crucial. This is even more so because gender cuts across all economic, cultural, social and religions dimensions.

The Linkages between gender and health

Gender refers to the socially and culturally defined differences between men and women (sex being the biological difference). It includes the different roles ascribed to the two sexes and the expected behaviour from each. It also includes the differential power and control, or lack of it, vested in each sex. Nominally, gender does not indicate a hierarchy but in actual practice men and women do not have equal access and control over various kinds of resources and a definite hierarchy exists between the two, as is clearly evident in Indian society. Women are expected to eat only after the men of the house have eaten, girls are provided fewer years of formal education, women are expected to stay at home and are governed by strict rules even on her visits to the natal home. It would be a mistake to surmise that these differences will automatically reduce over time. While gender roles, expectations and behaviours do change over time, the assumption that the difference in hierarchy reduces is somewhat naïve. The increase in female feticide especially in the developed states like Punjab, Haryana and Gujarat is a case in point.

The subordinate status of women in society deeply influences their health status. This is clear from the few examples given above. The principal responsibility of women in many societies, including our own, is usually restricted to childbearing. This overemphasis on one biological aspect has led to situations such as early marriage and repeated child-bearing. Son preference, another strong trait of Indian society, has led to the heinous practice of sex-selective abortion and repeated abortions. All these have grave implications for women's health. Women's workload in many places is considered minimal, but a careful daily analysis reveals that women hardly have a moment to spare in the course of the entire day while men are entitled to their share of relaxation after a day's hard work. Women's subordinate status has also made her an easy target of family planning programmes in our country with the bulk of sterilisations being tubal legation operations. To add to this, women have very little autonomy to decide what they should do for keeping healthy. Many women's reproductive health issues, which are related to their genitals, are considered dirty and shameful, and hence women not only feel uncomfortable in openly discussing their problems. They also refuse treatment from male medical providers, who themselves are a product of society

and, therefore, have the common social and cultural biases vis-à-vis women and their abilities. In short the gender differences between men and women are reflected in:

- Vulnerability of illness
- Health status
- Access to preventive and curative measures
- Burden of ill-health
- Quality of care.

What needs to change

In order to enable women to access better health care services, a number of very important steps need to be taken. Policies and programmes need to change. A beginning has already been made with the introduction of new programmes and policies mentioned earlier. However, change is imperative at the service delivery point. More health service delivery points are needed so that women may access services more easily. But to have service providers understand and deal with women's health needs, both men and women medical professionals need to become gender-sensitive. This can be made possible by training health service-providers on gender issues. This will help them appreciate the context of the health problems of women and enable them to provide appropriate therapy. In other words, this would help them become better clinicians and managers.

APPLYING PARTICIPATORY PRINCIPLES TO TRAINING OF HEALTH PROVIDERS

Context

Health is a discipline which involves continuous up-gradation of knowledge and skills. Health providers are usually exposed to a process known as CME or continuing medical education which involves studying relevant journals, attending conferences and lectures in related topics. It is considered extremely important to keep abreast of latest the changes and trends and thereby provide the most up-to-date and effective therapy. Training in gender may also be considered a form of CME, because a gender-sensitive trainer is also client-centred. But this is easier said than done because unlike other subjects such as medicine, surgery or gynaecology and obstetrics, gender is not an information-oriented discipline. It deals instead with attitudes and behaviours. A training in gender perforce challenges many of the deeply held beliefs of the individual, and thus presents a totally different set of challenges for both the trainer and the trainee.

Usual training/learning that most of us are exposed to includes lectures, demonstrations, practices and self-study. These methods can be quite effective for transfer of new knowledge and skill but, unfortunately, prove quite ineffective is gender sensitisation. Concepts in gender usually mean nothing, unless understood at an affective (emotional) level as well. Some trainers argue that concepts in gender first need to be "felt" before they can be understood. The traditional training methods prove ineffective in making a learner "feel" In order to effectively understand the concept of gender and to start applying the learned concepts to behaviour, the twin principles of participatory training and adult learning are better suited.

Participatory training

The traditional meaning of training has been transfer of expertise from trainer to learner. In such training, explicit emphasis is often on transfer of knowledge, wherein the trainer:

- Defines the context and content of the learning,
- Remains in control of the learning situation,
- Is the repository of knowledge and experiences – is the expert.

This kind of training very closely mimics the school/college learning situation, the only difference being that it is of a much shorter duration and has a clearer and better-defined purpose. Unfortunately, this kind of training also has a number of implicit incorrect assumptions (both on the part of learners and trainers), such as:

- Increased subject matter knowledge automatically leads to desired change in behaviour/ competence,
- Knowledge is objective and value-neutral,
- Training is the responsibility of the trainer and the training institution.

This has led to a situation wherein although a large number of training exercises are being organised as part of new programme initiatives, training continues to be viewed as a punishment. Furthermore, despite repeated training and even when trainees are able to parrot definitions, there is very little actual change in the desired competence.

Participatory training principles, coupled with those of adult learning pedagogy, has emerged from the relative inability of traditional training in dealing with adult learning situation, particularly when dealing with attitude and motivational aspects. Pioneered by Paula Frere (a noted educationist from Brazil) and Malcolm Knowles (an educationist from the U.S.), this approach is a departure from the usual school/college model of learning/teaching. Some of the assumptions of this approach include:

- Knowledge is almost never value-neutral. Where health care is concerned, the health care provider has the knowledge about the human body and its working, the source of wonder for the common person who then equates the doctor to a God. Doctors are often unwilling to share with the patients the causes and details of the disease, and if they do so they use such abstruse jargon that the person hardly understands what is being told.

- Knowledge does not automatically lead to change in behaviour or action. It requires that the person needs to be convinced first. In the case of gender, this is a block at every stage. Men in most part of our country are brought up believing that they are superior. This reflects in all forms of discrimination that many of the trainees themselves would be practicing. To assume that the mere definitions of gender and gender discrimination and a statutory mention of equality will change such deeply entrenched values is being

naïve. In order to do so, the provider must be convinced, understand the feeling of discrimination himself/herself before she/he will take any steps in her/his life to reverse the trend.

- Learners themselves are a rich source of experience and knowledge. The primacy of external information in the entire learning process often undermines the importance of experience. For adults who have already spent a considerable portion of their lives, experience is a rich source of learning. In order to take their learning forward, these learners must examine their own state of current knowledge (which is based on their experiences) and then take the learning forward. This makes their learning more permanent and also introduces a process of constant re-examination and introspection. Learning stops being a static process, increasing in quantum in a stepwise manner during training exercises to a situation where training accelerates an already ongoing learning process.

- The collective is a powerful medium and tool for learning. School/college type learning emphasises individual learning, especially through the system of individual examination and tests. But where individual experiences are supposed to provide an important component to the learning process, the collective provides a much larger experience bank to deal with. Further the collective also allows for a more thorough analysis of experiences, a sharing of different perspectives and a medium for trying out new hypothesis and behaviours.

- A final assumption that is the underpinning of this approach is that people can change, but they can and will change only if they are themselves convinced on the need to change. Thus, if a training exercise is relevant to the life of an individual trainee, she/he will learn (at her/his own pace and needs), provided a supportive atmosphere is provided.

The practice of participatory training

In order to actualise these principles, special care needs to be taken in conducting a training session. Some of the key considerations that need to be kept in mind while conducting participatory training, and the ways of doing so, are described below. The training workshop should be:

- Learner-centred
- Comfortable, respectful environment
- Openness- supportive environment
- Co-operation and collective learning
- Learning through active discovering/analysis
- Importance of learner's experiences
- Trainer as facilitator.

Seating

The usual arrangement of a learning situation is hierarchical. Usually, the trainer is seated at one end with the learners in rows away from the trainer. This arrangement does not allow much interaction between learners and between learners and the trainer and establishes a hierarchy with the trainers as different or superior. A circular seating arrangement is more democratic and allows for greater all-round interaction. A seminar/conference type seating arrangement around a table is imposing and may inhibit some individuals. A more informal circular arrangement either on chairs or on the ground may be more suitable for gender training. These adaptations allow the training to be learner-centred, and encourage a comfortable learning environment.

Inter-participant interactions

This is essential if there has to be collective learning. In many training workshops, participants are seldom encouraged to interact with each other. The women usually sit as a clearly defined group, as do men participants. Official hierarchies are strictly maintained. In order to make the participants comfortable and to challenge established hierarchies and patterns of behaviour, it may be a good idea to encourage participants call each other by their first names, sit in a gender-mixed manner, use ice-breaking exercises to promote friendliness and increase group energy.

Ice-breakers/energisers

These are short fun exercises which enable the participants to become uninhibited, release stress and increase interpersonal communication. These are essential for building trust, comfort levels, breaking hierarchies, etc. If possible, trainees themselves should be

encouraged to conduct games and facilitators should participate so that it reinforces the conscious breakdown of hierarchy.

Group tasks and exercises

These will enable the participants to work cooperatively with others. It enables collective analysis and problem solving, enables negotiation between group members and also encourages group norm setting and action.

Use of experience based learning methods

These can include case studies, films or even role plays. This encourages the use and analysis of experiences and development of theoretical frameworks based on experiences.

Learners contribute to the training agenda and in the management of logistics

This is done by including a session on expectations and evolving the training objectives in line with these expectations. Unrealistic and unrelated expectation can be removed from the agenda, but this is done in a transparent and democratic manner to make the training more learner-centric. Trainees should be made responsible for simple logistic arrangements like time-keeping, arrangement of the training venue and reporting, display of materials, keeping charts and group work done by participants.

Trainer as facilitator

Two-way communication is a key feature of participatory training. The learners should be encouraged to make guesses and independent analyses, and the facilitators should not thrust their own analyses on learners. If a particular exercise does not lead to the desired learning conclusion, the trainer should not dismiss the conclusion arrived at but simply state a different way of looking at the situation (the desired learning outcome). Participatory training encourages questioning and clarification of doubts. This means that the trainer cannot deliver a predetermined lecture and expect the trainees to learn. The facilitator has to be prepared to answer queries and clear doubts from different perspectives, and this means that the trainer needs greater mastery over her/his subject. This does not preclude the trainer from acknowledging that she/he does not know about a certain matter, and promising to check that up as soon as possible, and then informing the group.

Trainer teams

Since participatory training is activity/exercise-based and encourages a two-way interaction/ communication, it demands physically greater energy to facilitate than a lecture-based training session. Thus, it is often a good idea for trainers to work as teams rather than as individuals. This not only enables the trainers to share different tasks, but also enables greater interaction between the trainer and the facilitators.

Flexibility

The training schedule has to be flexible to incorporate new learning agenda, participant's pace of learning and so on. This flexibility is in line with learner-centredness, but should not be an excuse for learners/trainers to let chaos prevail. Learners should also be encouraged to be flexible, especially for the timing of the training exercise. Once the need for the training has been jointly established in the session on "hopes and expectations", the learners should be responsible for meeting these expectations within the stipulated time frame. Gender training requires intense interaction, which is not possible within a ten to five training framework. Therefore, evening hours are also used for showing films, having discussions and debates. The trainers need to take care to provide a second break, if needed, before starting the late evening sessions. Hence a non-negotiables of a gender training workshop is that it is residential.

AN INTRODUCTION TO THE USE OF TRAINING METHODS USED IN THIS MODULE

Participatory training uses a wide variety of training methods and this leads to a situation where any training using a variety of methods gets labelled as participatory. As it is clear from the discussion in the earlier chapter, the use of any particular method does not make a training session participatory, but adherence to different principles does. It is a challenge for trainers to use different methods in such a way that they enable two-way communication, allow for collective analysis, are experience-based and proceed towards action. A further challenge is how to choose an appropriate method for the subject that is being dealt with. A brief introduction to the different methods and the rationale for their choice is provided below.

Participatory training uses a variety of training methods – small group discussions, case studies, role-plays, films, exercises and so on. In order to determine which method is most appropriate for a particular subject, a simple rule of thumb may be applied. The trainer needs to decide on the focus of learning of a particular session – the focus of learning is usually one of the three – knowledge, awareness and skills (or at the most a mix of two). Where the focus of learning is knowledge, methods like interactive lectures, slide shows, data, reading materials, etc. can be useful. Where the focus is attitudes or awareness, the methods are more complex and can include group discussions, case studies, role-plays, films and exercises. Where skills are the focus, it is best to use methods like demonstration and practice. The challenge is to use a particular method/tool and then link it with the learner's own experiences.

Taking a learning experience to action -Another challenge for participatory training is that it is action-oriented. The sequence of learning has to be arranged in such a way that the understanding of the participants develops in a sequential manner and then proceeds towards some concrete post-training action plans. Within each session, too, there has to be a certain direction which encourages analysis and action. This is possible by using the format – experience/exercise / analysis /action. An illustration of how this is done is provided after describing the different methods used.

The methods used in this module include

1. Films
2. Exercises/group tasks
3. Role-play
4. Elicitive /interactive lectures

Using Films as a learning method

Films have been used in three different sessions in this module — the session on socio-cultural determinants of women's health, on Gender based violence and on male participation. Films are being used in these sessions in order to place *real life* experiences before the trainees. Where socio-cultural determinants and violence are concerned, the films *Adha Asman* and *Nasreen O Nasreen*, respectively, have been specifically developed for training purposes. These films are able to place before the trainee group a wide range of experiences from a woman's point of view, something they may have not consciously been aware of earlier. These experiences then need to be integrated with the learners' own experiences, and this is done in the case of socio-economic and cultural determinants by posing the question "whether the situation of women is similar in their work area." This enables the participants to analyse their own experiences and make comparisons. It also clearly puts the poor health status of women and the related socio economic and cultural status of women firmly on the agenda. While this session does not actually lead to action, it sets the stage for further analysis and inquiry. In the session on violence, the film puts across violence faced by women in a stark manner. Violence, even though a widely prevalent issue, is often not openly acknowledged. Here the question that is posed before the participants is what they *feel.* This is done deliberately because gender-based violence is one of the ugliest and starkest forms of gender-based discrimination. If the reaction to this is not at the feeling level, the commitment to change will perhaps not be strong. But then, care has to be taken that participants are not blamed, for if they become too defensive, learning will stop.

The third film provides a new way of looking at male roles – experiences which may be difficult to come across in real life. The experiences of the characters in the film are then related to the experiences of the participants and suggest real action. But the point to be noted is that the action has to be proposed by the participants themselves. It is expected that since the participants are proposing the action, they will subsequently follow it in their lives

and professions. It must be emphasised that the film in itself does not provide much learning, but then the experiences must be processed/analysed. This analysis is best done in groups – either in a large group consisting of all the participants, or in smaller groups, which would be better.

Exercises

The proposed module includes exercises in several sessions. The exercise in each case is different, and there are group exercises in two cases and an individual exercise in one. The two group exercises on division of labour and RH in Session II and *Session II, respectively, are designed to stimulate collective analysis. On the basis of these analyses, the participants are expected to arrive at a conceptual understanding of how gender differentially affects women.

In using group exercises, the task must be very clearly set. In each case, it might be useful in providing examples while explaining the task, e.g. it is suggested that the facilitator do a gender analysis of one health concern as an example before asking the participant groups to do so in Session VI. The group division must be smooth and there should be no confusion regarding who is in which group, and then the task-setting should be done. It is a good idea to first divide the groups and then describe the tasks. The facilitators must constantly circulate between the groups in order to clarify doubts and to check whether the groups are progressing in the right direction. The groups must be provided with extra support if they are going astray or have not been able to understand the task. The facilitator must also check whether all participants are given equal opportunity to participate. When there are participants from an established hierarchy, or where there are a few who are familiar with each other, there is a possibility that some participants stand a chance of being marginalised, or tasks being deputed. The facilitator must gently discourage such practices. This cautionary note applies to all group discussion/tasks.

The third exercise in Session I is a quiz, which sets the context for the lecture on sex and gender. This exercise helps in contextualising the lecture. Details of conducting the exercises are provided in the session notes.

Role-plays

The use of role-plays is suggested in the last session on 'Providing gender-sensitive health services.' Here the role-play is being used as a method of evaluating what the participants

have learnt. Much of the attitudinal learning that the participants are expected to imbibe has to be translated into actual behavioural change. The practice of actually trying out new behaviour is being provided through the role-play. In this method, the whole group of participants gets a chance of consolidating their understanding of the socio-economic factors which affect women's health. The group then together works out a protocol on the behaviour of a gender-sensitive service provider. While the actual work is done by a few participants, the rest of the group gets an opportunity to offer suggestions and advice which sharpens their own analytical skills. Thus, a new type of real-life behaviour is tried out in the relative safety of a training workshop where it can be corrected and refined with the help of peers. However, it is important for the facilitator to ensure that the role plays-do not degenerate into a mere display of histrionics, which distracts from the main theme of the role-play itself.

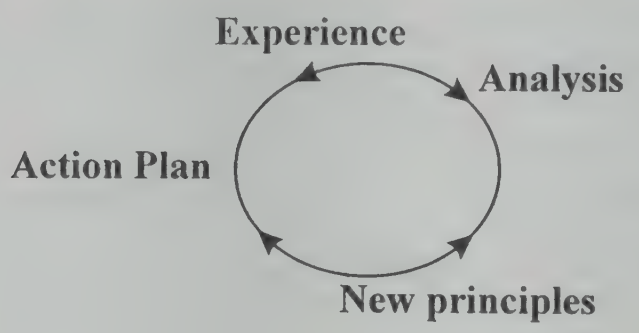
Elicitive lecture – Lectures form the basis of most training, but in this training they have been kept to a minimum. Even while delivering the limited number of lectures proposed in this module, the facilitator must keep in mind the training sessions should be as interactive as possible. In the session on gender and sex — a quiz (exercise) is proposed to contextualise the lecture. In this, the facilitator must be careful that the lecture is grounded in the reality of the participants. This is possible only if frequent questions are asked to get confirmatory examples and by checking out whether everyone is following.

QUALITIES OF AN EFFECTIVE GENDER TRAINER

Some key competencies of the facilitator in participatory training include:

Asking questions

Asking questions is one of the cornerstones of participatory training. When the facilitator asks appropriate questions, it helps in two ways — it allows the facilitator to understand the participant's background, and that can help in grounding the discussion at the level of the participants. The second use of questions is that it helps the participant to share her/his experience. An analysis of these experiences is then useful in arriving at new principles which can then be converted into new action. In this manner, a learning cycle is established:



This can be illustrated by the question sequences used in different sessions.

For example, in Session III, after the participants have finished presenting their group work, there can be following questions:

- Is there a pattern in the difference in unpaid work, access and control between men and women. Why is this so?
- Do multiple roles pose problems in seeking health care (time and mobility analysis)?
- Are women vulnerable to certain types of problems because of the kind of work they do?
- How does crisis affect men and women (e.g. mobility – Transportation during pregnancy complications)?

These questions lead from the activity/experience of the participants to the formulation of a

principle of differences between men and women in terms of work, access and control. This session does not go on to the action plan. That is done later in the course of the training.

Similarly, in the session (Session V) on gender-based violence, the participants are shown a film and then their feelings are linked to principles and action –

- After the film show ask the participants how they *feel* after seeing the film.
- How many types of gender-based violence do we come across in the film.
- Do the participants think that gender based violence is a common phenomenon?
- Are there any health consequences of gender-based violence?
- List the health consequences of gender-based violence.
- Ask the participants to think of examples linking violence with RH outcomes.
- Ask the participants how they would deal with a case of violence.

In this case, the entire cycle is followed and the final question deals with how participants would deal with a case of violence.

Debriefing consolidating and summarising

These three are essential components of any session. After a task has been set – e.g. film show with questions, group exercises or even role-plays — the group task has to be presented by the group and this presentation must lead to the required learning objective. This process requires debriefing, consolidation and summarising. After a group has completed its task the first job is to ask them to present their task. The presentation made by a group can be equally time-consuming. And if different groups have the same task, it may be good idea for different groups not to present their whole work but cover all the groups by asking each group to present part of their deliberations. The other way is to focus on the crucial aspect of the group work and asking the groups to only present one aspect. For instance, in the group task on gender analysis (Session VI), the groups can be requested only to present:

- Social vulnerabilities
- Response of family
- Response of health system
- Response of self

Alternately, two groups present two of these and two groups two other points. This can help in saving time without affecting the focus of learning. After the groups have presented their discussion, the facilitator either asks further questions on the presentation or uses the data Session III presented to draw conclusions. This drawing of conclusions with the help of data and discussion is known as consolidation and summarising. In some cases, the data is transparent and only summarising is enough. In others the common threads have to be woven and then we call it consolidation.

Listening

This is another key competency, and it may seem too obvious for being put up as a separate competency. Unfortunately, we do a lot of hearing but very little listening, which means that we seldom pay attention to what we hear, or analyse it and respond to it. Often, we have our own fixed notions about many things and despite hearing we do not carefully listen to what is being said and dismiss it. This cannot be done in participatory training. The facilitator must carefully listen to all the answers to the questions, evaluate them in the light of the learning objectives and then respond, respectfully. Dismissing ideas as absurd and irrelevant may antagonise participants, who will then try to disrupt proceedings. This may also lead to some important data being missed out. Different ways of sharpening listening skills is to ask questions/clarifications and summarising.

Preparation

This is another essential competency, if not an essential pre-requisite. Participatory training does not depend on one-sided communication and allows full freedom to the participant to ask question and challenge the facilitator. The facilitator must be prepared for these eventualities. Furthermore, participatory training methods often use a number of materials/ learning aids like instruction sheets for games, chart paper or OHP sheets and markers, etc. Thus, the facilitator must be prepared with:

- Training content
- Operational details of the method being used
- Debriefing and consolidation framework and
- Ancillary materials

All handouts must be photocopied and shared with participants at the end of the concerned session.

The challenge for a gender trainer

Medicine is becoming more and more an exact science where logic, evidence and replicability of experience are held as the precursors of truth. The new knowledge is applied into new practice and once the skill has been honed, the practitioner is free to apply the skill on his/her own. Also the acquiring of a new skill often leads to an increase of personal ability and competence. In short, one is better positioned to deal with a situation one is in better control of. In gender this is not necessarily so. The study of gender is not an exact science, and its principles are derived more from experience and observation rather than through logic and replicable experiments. The experimenter/student cannot be a disinterested party as she/he has her/his own assumptions, which she/he needs to challenge and understand and, if necessary, change. Gender training assumes that the trainer/facilitator is also a believer and a practitioner in the concepts that are being discussed.

A gender-sensitive person is expected to be considerate towards the person who is being discriminated against. In many cases, the doctors who come to attend this training are people in positions of authority and wield power over family members, members in their staff and their patients. After other kinds of training, this power can increase because the facilitator person now knows more, is more competent, but after gender training the person is supposed to become more considerate, give up power over patients and also over family members (gender is a very personal issue as well). This relinquishing of power can be threatening and may make the participants feel uncomfortable. The facilitator needs to not only verbally encourage individuals but also provide a model. The facilitator usually is a person with authority, but the facilitator in a gender training workshop must set an example through her/his own behaviour. She/he needs to share this authority with the participants. This can be a powerful learning medium for the participants.

Other essential qualities of a gender trainer include

- Friendly, interactive and with good communication skills
- Humility and openness
- Flexibility
- Resourcefulness – one needs to be able to think up alternatives. Remember the Peter principle
  – anything that can go wrong will.

Conducting the gender sensitisation workshop

Pre-workshop preparation

Conducting a workshop is not the only responsibility the facilitator has. Often, the facilitator also has some administrative responsibilities related to the workshop. Thus the pre-workshop preparation can roughly be divided into content-related preparation and administrative preparations. As far as content-related preparations are concerned the facilitator needs to:

- Understand the background of participants – where they are coming from, what are they expected to do when they go back;
- Review the training design- match its objectives and proposed methodology with the need and profile of participants;
- Prepare for and strengthen the theoretical understanding (knowledge) on the different sessions that the facilitator is supposed to conduct;
- Identify appropriate reading material;
- Prepare any training material that needs to be made, etc.

The administrative arrangements include:

- Decision on the dates according to convenience of trainees, other resource persons as well as keeping holidays and festivals in mind;
- Information to the participants;
- Finalisation of the venue and arrangements – whether these are they appropriate for the kind of workshop being arranged;
- Arrangement for stationery and other aids like TV, VCR, OHP, etc.
- Arrangement for the duplication of reading material;
- Check the food and board arrangements;
- Travel arrangements for participants and other resource persons;

During the workshop

As indicated above, the facilitator may have two different kinds of responsibilities during the workshop as well. While it is best to get individuals to assist in separate jobs, such as for the administrative aspects of the workshop, it may be the responsibility of *in house* facilitators (as opposed to guest facilitators) to look after some of the administrative arrangements. During the workshop the facilitator must be able to follow the pulse of the participants very closely. While the design remains a guide for conducting the workshop, the facilitators must be alive to the need of adjusting the design according to some emerging needs and issues in the participants. In most workshops, there is more than one facilitator and there is a great need for the facilitators to continuously check with each other about the situation of the group and the progress of the workshop. In most workshops with more than one facilitator, the common practice is that facilitators only come in during their own sessions and then leave. This is not a good practice when using a participatory methodology. The other facilitator should also continue to stay on in the session and fulfil supportive roles like

- Assisting the main facilitator to check whether everyone is joining in;
- If there are group tasks given then the co-facilitator can go around the groups and help in clarifying the task;
- The co-facilitator can act as an extra pair of ears and eyes as well- noting when someone wants to make a contribution or has a question, and drawing the attention of the main facilitator to that person
- The co-facilitator should refrain from making any content-related contribution to the session, but if she or he feels the absolute urge to do so, then she should do so only after taking permission from the main facilitator.

When two facilitators are present, it is usually easier to gauge the progress of the workshop as well as make mid-course corrections. A team of facilitators helps in having continuous feedback from colleagues and contributes to improving the quality of workshop.

Things to look out for

Any workshop conducted according to participatory principles is an occasion for different kinds of group processes to manifest themselves. These processes can be very useful in carrying the learning process forward, but can also be counterproductive. The facilitator must be skilled in understanding the processes that are taking place during the workshop,

use these to further the learning process as well as diagnose possible disruptions and take preventive action. These are special skills required of a facilitator of participatory workshops and training exercises because in the traditional set-up, learning is expected to take place at the individual level and interactions between/among participants is neither necessary nor encouraged.

Whenever a number of individuals interact with each other in a common domain (or group), it has been observed that they go through some common processes. Various bahavioural scientists have described these processes, and a common framework for understanding their behaviour is given below:

- When they meet together, they try to check out who the others are. If there are a few they know, they tend to stick together to be comfortable. Other individuals try to see what are the levels of the other participants – what will be the level of "my" influence. This initial stage where all the participants are trying to find their place within the group can been called the ****stage of forming***. At this level, the work is usually done at the individual level.

- After this, individuals tend to start making linkages with others they did not know, but this is done tentatively with one or two individuals at first and dyads, triads subgroups form. Work is still being done at the individual level, though the pairs and triads can be made out by observing how participants sit, or respond to each other and so on. This stage has been described as the ***Stage of Storming***.

- In the third stage, the ***Stage of Norming***, individuals and pairs reach out to other members of the group, they start making common norms for group functioning. The group is now more relaxed and is able to work together.

- The final stage in the development of the group takes place when the group is able to autonomously take responsibility for its actions. Given a task the set out to achieve it with minimum fuss and maximum efficiency, with little time lost in members getting distracted. Such a group tends to arrange itself in a manner where all members can participate (circular seating), divides responsibilities by consensus, individuals help each other and there is an overall sense of ownership. This stage has been called the ***Stage of Performing***.

For facilitators it is essential to make out where the participants are in terms of group development and then they can assist the process.

In the initial stages, some individuals tend to behave in certain set ways like being aggressive and posing challenges before the facilitator, resisting, continuously trying to draw the attention of the facilitator to herself/himself, and so on. The facilitator must be able to recognise this kind of behaviour. This kind of behaviour is usually a resistance to the facilitator's authority, or to getting recognition within the group. The facilitator must accordingly try to talk to the person outside sessions and win their trust. The important thing is to realise that this kind of behaviour has the potential to disrupt the proceedings, as well as lead to awkward showdowns. These should be avoided as far as possible. Cultural programmes can assist in speeding up the development of groups.

Logistics

In a participatory workshop or training it is always a good idea to encourage participants to share in the arrangements. This makes the participants directly responsible for their own learning as well as share in the overall conducting of the workshop. Some things that the participants can be made responsible for are:

- Maintenance of the time schedule;
- Checking arrangements regarding food and board;
- Daily reporting;
- Keeping a pulse on the learning processes – if everyone is being included, if the topics are being discussed in a manner that every one is able to understand, and so on.

These responsibilities can be shared by a larger group of participants by constituting daily task groups on a rotating membership basis.

Schedule

The sessions are organised in the following section in an order which can be followed by the facilitator without much difficulty. Any workshop should start with a session on introduction, but if the Gender and RH module is placed within a larger training format, one should be careful to check whether the group is sufficiently familiar with each other. If they are then the Introduction session can be dispensed with. The session on Socio-cultural

determinants of health is kept as the first session, because this will enable medical officers to see women's health problems from a different angle. It is then followed by sessions which allow them to understand the difference between men and women and how many of these differences have been socially constructed. If the facilitators wish to change the arrangement of sessions, there should be a sufficiently valid reason for doing so. This is because the order of sessions has a certain rationale and flow, which may be disturbed. The sessions have been such arranged that they can be easily conducted in about a day and a half (including the introduction and the hopes and fears sessions) If there is less time at the disposal of the facilitator, the introductory sessions can be removed.

It is a good idea to have a daily morning review session in which the earlier day's sessions can be revisited and doubts clarified.

Also, if there are opportunities where sessions on gender-based violence or male participation need to be conducted, the session notes given later can be useful.

Post-workshop follow-up

Workshops like these are essentially meant to lead to a change in the behaviour of the participants, and not just bring about a change in their knowledge level. It is always interesting for the facilitator to know if this happens. It is easier said than done, but it may be possible if the participants are provided and an opportunity to plan for some specific changes and then the facilitators can informally or formally follow up on these plans through a letter, if not anything else. The facilitators can also leave their contact information with the participants for later interaction.

Ideally, workshops like these should have follow-up workshops, but that may be difficult within the present framework of RCH training.

HOW TO USE THE MANUAL

The Manual contains 10 Sessions. Each Session follows the sequence given below:

- **Session Title** — This identifies the main topic of the sessions. This must be shared with the trainees/ instructors at the beginning of the sessions.

- **Time** — It indicates approximate duration of the sessions. Resource persons are expected to follow the time allotted for each session and activity/task (where prescribed). Resource persons should try to conclude the session within the given time frame. Incomplete sessions will be of no use.

- **Session Objectives** — It describes what participants will be able to do by the end of the sessions in order to demonstrate increased knowledge, improved skills or changed attitudes. Objectives should be written on the flip chart/ blackboard before the sessions. The trainer should start each session by presenting the session objectives. The trainer should try to re-read the session objective towards the end of the session to enable participants to assess whether the session objectives have been accomplished or not.

- **Expected Outcome** — These are the suggested core points of discussions. It is expected that discussion around the given points will enable the participants to accomplish session objectives. However, if time and situation permit, you can add more points.

- **Methodology** — It explains the methodology adopted by trainer to conduct the sessions in participatory manner

➢ **Note to facilitators**	Therefore, you must study these before conducting the Session. They contain additional information, which should be used by trainer while conducting the session. This could be shared with trainees.
➢ **Facilitator's Guidelines**	These provide specific instructions to the instructor/ resource person. These notes are only for the guidance of the trainers and are not to be shared with the trainees. Therefore, it is very important to read, understand and, if possible, rehearse the session steps before taking the session.

SESSION PLAN FOR THREE DAYS STANDALONE GENDER TRAINING

Name of Session	Course Contents	Method	Time
DAY ONE			Total 7 hours
Pre-workshop questionnaire	Participants fill up the pre-workshop questionnaire	Individual form-filling exercise	30 minutes
Hopes and fears and introduction to training objectives	To know the expectations of the participants. To link the participants expectations with the objectives of the workshop. To help reduce participant anxieties	Individual exercise	60 minutes
Ice-breakers	To introduce participants to each other and set the mood of the workshop.	Introduction in pairs/ triads	60 minutes
Session I Concepts of gender and gender stereotypes	Examines the basic concept of gender and to clearly differentiate between sex and gender	Gender quiz, interactive discussions	90 minutes
Session II Gender stereotyping	Exploring the concepts of man and woman, feminine and masculine	Case study, content analysis of popular sayings, adages	60 minutes
Session III To understand gender roles and responsibilities	Women's work burden Access and control over resources based on gender How work roles impact health	Bar chart game	120 minutes
DAY TWO			Total 7 hours
Session IV Introduction to ICPD	To highlight the ICPD perspective in population development programmes	Presentation	60 minutes
Session V Social , economic and cultural determinants of women's health/ RH	Gender as a component of larger socio cultural and economic issues Socio cultural constraints on women's health	Film or web game	90 minutes
Session VI Reproductive health and gender	Concept of RH Understanding differential	Group work, presentation and	120 minutes

	health needs of men and women All RH issues have a gender base	discussions	
Session VII Gender-based violence and RH	Impact of violence on RH Role of providers in addressing gender-based violence	Film , discussion	150 minutes
DAY THREE			Total Hours : 6h 30 minutes
Session VIII Male participation	The importance of male participation in RH To discuss ways of enhancing male participation in RH programmes	Film, group work and discussions	120 minutes
Session IX How to provide gender sensitive health services	Understanding applications of gender sensitive health service Develop gender sensitive indicators	Role play/ discussions	90 minutes
Session X Population myths and facts	Reviewing understanding of concepts through a set of statements, identification of myths and facts	Quiz, individual exercise, and discussions in plenary	90 minutes
Session XI Evaluation of training	Training evaluation questionnaire	Individual exercise	30 minutes
Session XII Commitments	Participants document their commitments in a format provided for the purpose	Individual exercise	60 minutes

SECTION II

Conducting the Training

SESSION NOTES

PRE TRAINING QUESTIONNAIRE

Time 30 minutes

Note: The participants are requested to answer the following questions before the workshop. They are requested to provide their answer as per their understanding and experience.

Name of the participant :

Sex :

Designation and place of posting:

1. What motivated you to come to the workshop? Was it selection or by choice?

2. What do you hope to get out of this workshop?

3. What are your fears regarding this workshop?

4. What will contribute to this workshop? (Special experience, certain skills, aptitude)

5. Have you attended gender training workshop before? If yes, specify.

6. What do you think is meant by the term gender?

7. What are the main gender issues related to your work?

8. Do you think gender is linked with reproductive health? Give reasons for your answer.

9. Do roles and norms for men and women determined by society affect men? Give reasons for your answer, and provide examples to illustrate your answer.

10. Caring for children is women's responsibility? Agree/disagree

11. There are more men leaders in society because women lack leadership qualities. Agree/disagree

12. Societal norms for men and women are appropriate Agree/disagree

13. All diseases (except gynaecological diseases) affect men and women similarly. Agree/ disagree

14. Men have more knowledge mainly because they have more exposure to the world. Agree/disagree

Facilitator's Guidelines

This is required to benchmark participants' knowledge on gender before the training. It serves a useful purpose, for doing a process documentation of gender training and for any impact evaluations undertaken in future. Please conduct this exercise as soon as possible. It may be given to the participants individually as they come in or as a group, but in no case should the participants consult each other when they fill it up.

I. INTRODUCTION

Objective: To introduce participants to each other and set the mood of the workshop.

> ***Note for the facilitator:***
>
> If this is the first session of the training programme, it will be necessary to welcome the participants before the introductory session. If the gender module is conducted in the middle of the training, this session may be dispensed with because the participants will by then become have become familiar with each other. If the trainer fells that the participants are not adequately familiar with each other, the introductory session must be conducted. The Introductory Session is usually divided into two steps – the formal introduction and more detailed introduction. Formal introduction is usually done by asking the participants to mention their names and the place of work, in turns.

The detailed introductory session may be conducted in a number of ways. Two options are being provided here.

Method 1: Ask the participants to break up into pairs/triads. Give each pair/triad a set of questions to discuss about each other. Give the pair/triad a specific amount of time to conduct their queries. At the end of their discussions, ask all the groups to reassemble in the plenary and then each person introduces the other. If there are three persons then person A can introduce person B and then B can introduce C and C can introduce A. A list of illustrative questions is given below.

1. Ask each participant to give herself/himself an adjective that she or he thinks best describes her/him, and introduce their name along with the adjective, e.g Affable Anjali, Naughty Narayan, Kind Krishna, etc
2. What is your favourite food item/film star/ TV serial?
3. Why did you decide to become a doctor/choose this profession?

4. How many persons do you have in your family?
5. What are the kinds of tasks you are good at or like doing?
6. What are your special skills and how do these skills help you in your work?
7. What is your favourite hobby/pastime?

The participants can be divided into pairs in a number of interesting ways. One interesting way is to make matching picture cards or word cards, e.g. needle-thread; pen-ink; syringe-ampoule; tablet-capsule and so on. These cards can then be pinned to the backs of the participants and they are asked to identify their pair without speaking with each other and asking questions and giving answers through acting (dumb charades). This exercise also acts as an ice-breaker.

Method 2: The participants are asked to walk around the room in any manner – zigzag, round and round, up and down or a combination of these. The facilitator will call out a number from 2 to 5, and the participants are supposed to make groups of that number. Each time the participants form a group, the facilitator calls out a question (see the list given above), and asks the participants to share the information with each other. After sharing, the participants again start pacing about the room till the facilitator calls out another number. This process can go on till all the participants get a chance to talk to each other.

I. HOPES AND FEARS and INTRODUCTION TO TRAINING OBJECTIVES

Objective: To know the expectations of the participants.

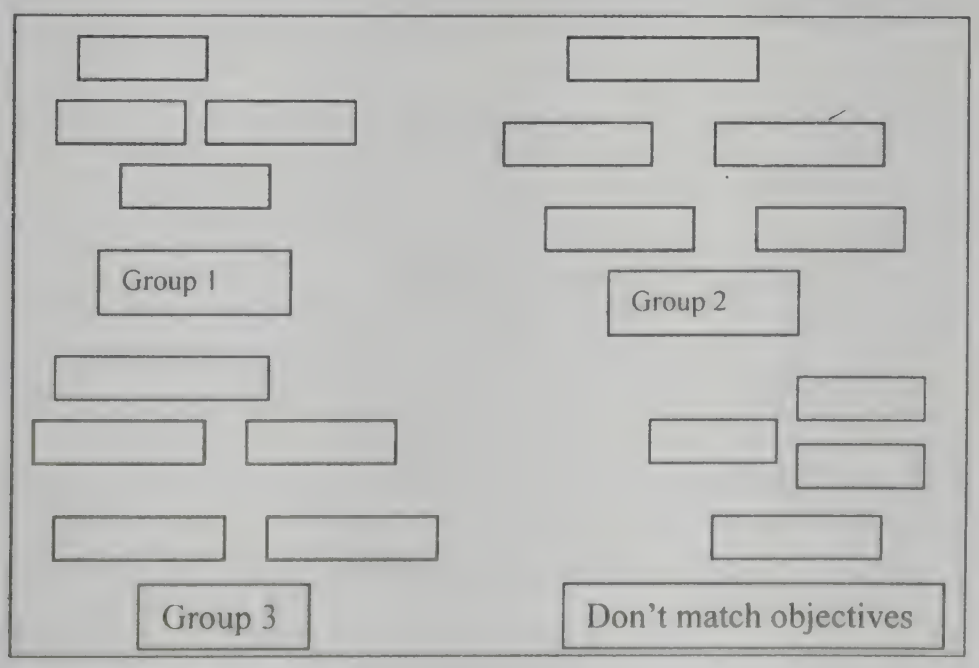
To link the participants' expectations to the objectives of the workshop.

To help reduce the participants' anxieties.

Methodology:

Step 1 — Distribute two pieces of coloured (9"x 4") chart paper to each participant and also provide them with a marker pen each. Ask them to write two points related to what they hope to learn/get out of this workshop. One expectation must be written on one chart paper. After the participants have written their "hopes", give them a chart paper of a different colour. Ask them to write one "fear" they had when they came to the workshop. Give some examples if the participants do not understand what to write (eg. someone ill at home, children's examinations, how I will reach in time, how will facilitators will be like, etc.).

Step 2 — While the participants are writing down their fears, the facilitators quickly read the "hopes" and classify them according to how they match with the objectives of the training. The trainer sticks these expectations in groups – some groups which relate theirs to the objectives of the training and one/two groups which do not (group number 1, 2, and 3 in the illustration given below relate to the objectives of the workshop while the fourth group has those hopes which will not be dealt with in this workshop). An example of how the pieces can be arranged is given in the diagram below:



Read out the fears first and assure the participants that whether and how these fears will be taken care of (if at all) during the workshop. Then read out the list of expectations in the groups. Read out the ones that don't match the objectives and take the permission of the participants to remove them from the official list of expectations. Inform the participants that because of time constraints it will not be possible to address all their expectations. Now, tie up each group of expectations with the related objective. Write out the objectives on a chart paper and stick it up on the training room wall. This chart should stay on the wall to monitor the progress of the training.

Objectives of the workshop

- To understand the linkages between gender and RH and its impact on women's overall health;
- To increase capacity of the medical officer in providing gender-sensitive health services, both as a clinician and as a manager.
- To develop a set of indicators for gender-sensitive RH services*

Logistics and arrangements

After stating the objectives of the training, the logistics and arrangements can be defined – starting time, lunch and tea times, till what time the sessions will go on in the evening, and so on. It is also a good idea to ask for five volunteers – two who will prepare a report of the day's proceedings and present it next morning and three who will see to it that the logistics arrangements – especially timings are being maintained. Calling people to come at the right time will be their responsibility. These volunteers are changed every morning.

SESSION I : CONCEPTS OF GENDER

90 minutes

Objective: To examine the basic concept of gender and the difference between sex and gender

Core message: Sex is biological, gender is a socio-cultural construct of men and women.

Expected outcome: Participants are able to clearly differentiate between sex and gender.

Methodology: Gender quiz, interactive discussions.

STEP I

Ask the participants to define what is sex and what is gender, in pairs (give them 5 minutes) Write down their definitions on two chart papers.

STEP II

Circulate a set of statements to each participant and ask each one to identify each statement as sex or gender or both (S/G). Ask the participants to share the copy ticked by them with some other participant and then discuss each statement in a plenary.

- ***Women are better at caring for children than men (G)***
- ***Body hair is OK for men, but women have to remove it (G)***
- ***Women breast feed babies (S)***
- ***Postmortem is done by male doctors (G)***
- ***Male voice break at puberty (S)***
- ***Men are sexually more aggressive than women (G)***
- ***Women menstruate and also undergo menopause (S)***
- ***Men are soldiers, because they are brave and can use weapons to fight (G)***
- ***Women have broad hips than men and so their gait is more attractive (G)***
- ***Women's illnesses are mostly psychosomatic (G)***

STEP III

Define gender' based on discussions and use this table to assist in summing up.

SEX	GENDER
Biological	Socio cultural construct
Nature-made	Society-made
Constant	Variable
Individual	Systemic
Non hierarchical	Hierarchical
Cannot be changed	Difficult not impossible

Explain what each of the above terms means (e.g.- variable/constant, hierarchical /non-hierarchical, can be changed/ cannot be changed etc) with copious examples from real life. Also explain how gender gets constructed from early childhood and how as individuals we have our ideas formed by societal norms. This can be a cause for problem both with women and men.

Facilitators Guidelines:

- Guide discussions and, as far as possible, encourage participants to respond to questions that come up and step in to facilitate discussions. This is a very effective way of resolving differences among participants.
- As traditional thinking is being challenged in this session, discussions need to be carefully guided.
- Tendency for too many speaking at a time must be regulated by the facilitator.
- Make the participants speak from the standpoint of their experiences and personal lives.
- Encourage participants to question why small and listed differences should lead to unlimited number of gender differences.
- Try to bring up health issues by showing interactions between biology and gender.

SESSION II : GENDER STEREOTYPING

60 minutes

Session II: Gender stereotypes

Objective: To explore the concepts of man and woman, feminine and masculine attributes/ qualities.

Core message: To understand association of positive and negative images with roles of women and men

Expected outcome: Participants see how this association plays itself out in the Health systems.

Methodology: Case Study, analysis of popular sayings and adages, discussions

STEP I

Use one or two case studies. Ask the participants to read the case individually and respond to the question at the end of the case study. (This could also be done in two groups).

CASE STUDY I

Angad and his father are driving back from school. Their car is hit by a truck and the father dies on the spot. The son is brought to the hospital by some unknown persons for an emergency operation. The surgeon looks at the boy and is too shocked to perform the operation and says "I cannot do the operation. He is my son."

Q. How is this possible?

The answer in this case is that the surgeon is the boy's mother.

CASE STUDY II

A taxi driver meets with an accident and is brought to the hospital where the nurse, seeing the body, faints saying "Oh, no that's my wife".

Q Are you surprised? Why?

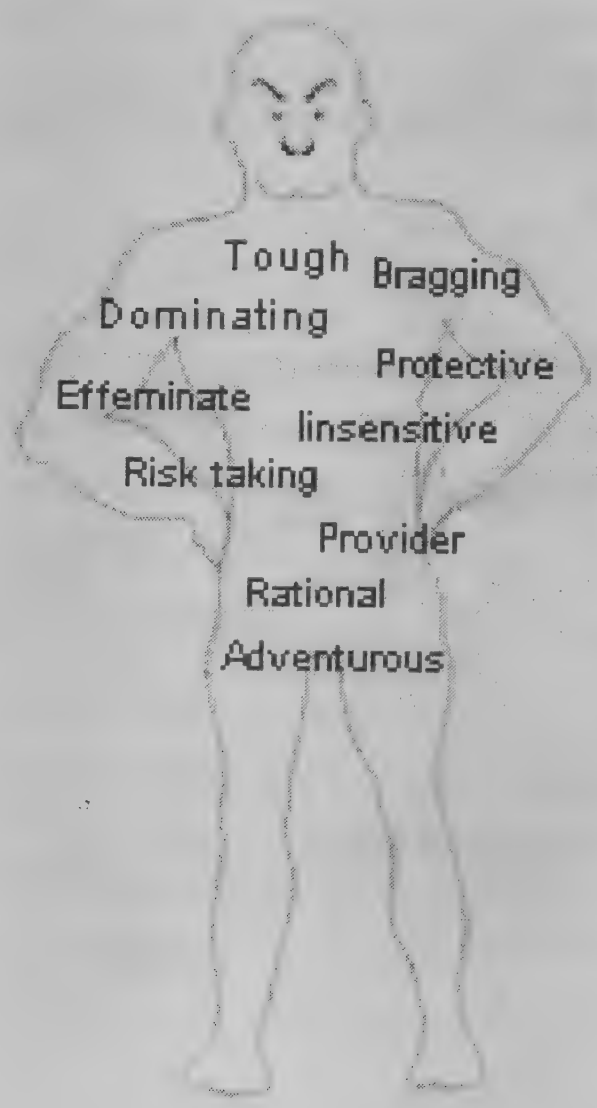
The answer in this case is that nurse is the husband of the victim and the taxi driver is his wife.

In both case studies, how many could identify? Why could others not identify? Explain how stereotypes take place.

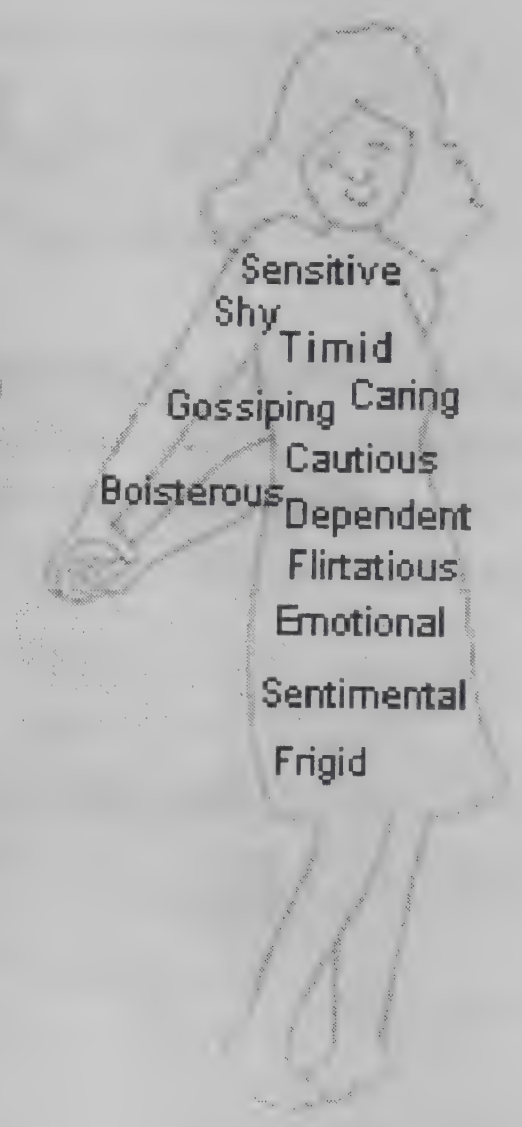
STEP II

Ask the participants to list the qualities of men and women (draw the picture of man and woman and write the qualities within, as below) guide the discussion.

A MAN IS



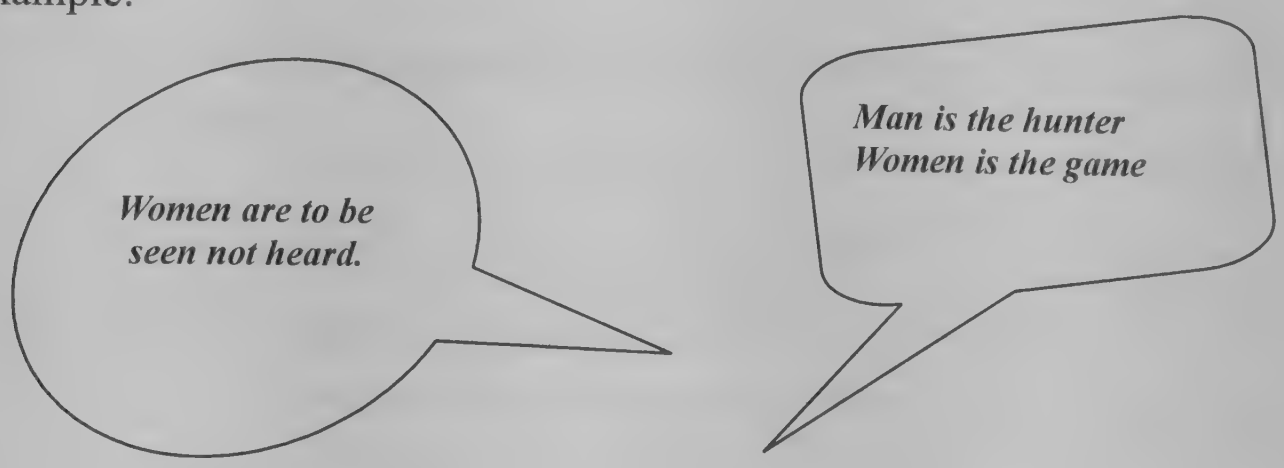
A WOMAN IS



STEP III

Use some adages or popular sayings in the language participants understand or are familiar with which enforce norms/behaviour/qualities arbitrarily applied to men and women. Discuss whether these perceptions need re-evaluation. Emphasise the importance of respect to human nature, individual choices and preferences. (Complete the spaces with things that people say).

For example:



STEP IV

Ask the participants to discuss impact of stereotyping on women's health and how they are played out in the health systems?

Example:

Women tolerate violence, fear speaking out on sexually related illness, women are unable to negotiate use of condoms, fear of speaking out on sexual abuse etc.

Facilitators Guidelines

Guide the discussions on the above to explain the following

- Exposure and practice decide what men and women do and do not do. This is not based on sex.
- We internalise what we learn from birth in our families and believe that is reality.
- By doing so, we restrict choice for men and women.
- Women face more restrictions on account of stereotyping.
- We use male norms to determine efficiency and competency or otherwise.
- Link the discussions with the introductory session in which participants shared what they can, cannot, and wish to do as women and men.

SESSION III : GENDER ROLES, ACCESS, CONTROL AND DIVISION OF LABOUR

120 minutes

Objective:

- To understand men and women's roles, particularly multiple roles of women.
- The differential access to and control over resources for men and women.

Core message: To understand gender division of labour and how it is a determinant of health and well being.

Expected outcome: To understand how access and control over resources in meeting health needs are affected by gender roles.

Methodology: Bar chart Game, Group work, Discussions

STEP I

Bar chart game on gender division of labour

The participants are divided into 4 or 5 groups and each group is given a paper with a circle divided into a bar chart with twelve bars), each bar representing the following:-

1) Paid work hours
2) Nursing the sick/aged in the family
3) Taking care of livestock
4) Child care
5) Decision-making in fertility regulation/contraception
6) Political participation
7) Control over resources and income
8) Ownership and managing of property
9) Access to schooling and education

10) Sleeping, recreation and entertainment

11) Access to credit

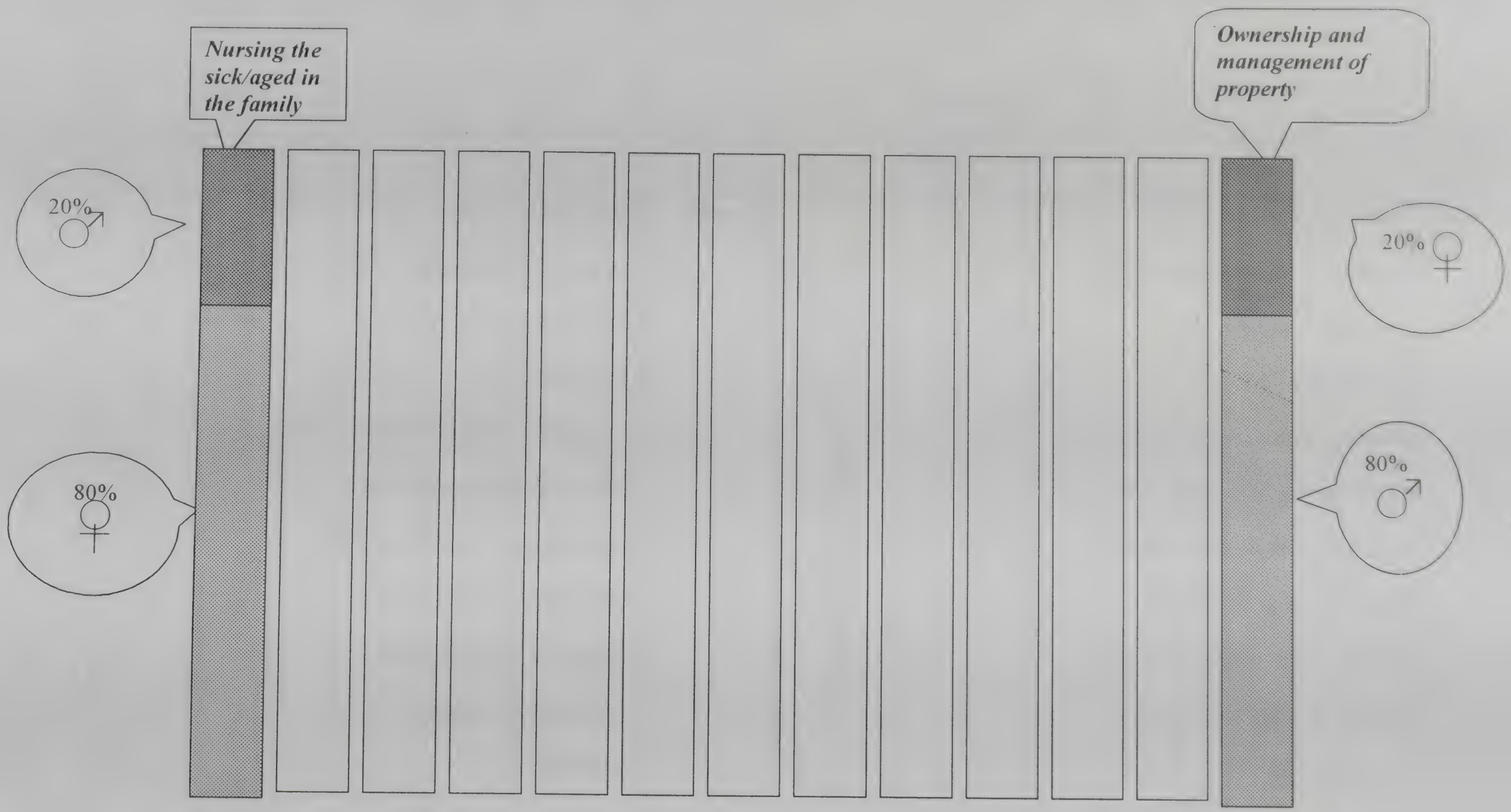
12) Facilities to carry out tasks/activities

Participants are asked to divide each bar for men and women (according to the percentage of access to and control over resources exercised by men and women, in general) in two different colours. In each segment the participants are asked to mark logos indicating men and women, as shown on next page.

Note to Facilitators :

The international logo for men and women is as follows

Women ♀ Men ♂



The participants are given 10 minutes to complete the task and then each group makes its presentation. During the presentations the facilitator fills in the different percentages mentioned in a chart (format given below). It demonstrates that men and women have different roles, unequal responsibilities and access.

		Groups						Groups			
		1	2	3	4			1	2	3	4
Men	Paid work hours - M					Women	Paid work hours - M				
	Nursing the sick/aged - M						Nursing the sick/aged - M				
	Livestock care - M						Livestock care - M				
	Child care - M						Child care - M				
	Decision-making in fertility -M						Decision-making in fertility -M				
	Political participation -M						Political participation -M				
	Control over resources -M						Control over resources -M				
	Ownership property-M						Ownership property-M				
	Access to schooling-M						Access to schooling-M				
	Sleeping, recreation -M						Sleeping, recreation -M				
	Facilities -M						Facilities -M				
	Access to credit -M						Access to credit -M				

Discussions

- Is there a pattern in the difference in unpaid work, access and control in men and women. Why is this so?
- Does multiple roles pose problems in seeking health-care (time and mobility analysis)?

  (For example: Women have no time to spare to go to the doctor at the time the clinic is opened. Men have mobility and do manage to reach out for services)
- Are women vulnerable to certain types of problems because of the kind of work they do?
- Women nurse and care for the disabled, old and sick. So does she have greater chances of getting infection?
- How does crisis affect men and women (e.g. Mobility – Transportation during pregnancy complications)?

Consolidate the discussion by explaining how women's roles, access and control affect her health.

Definitions of Roles of men and women

i) **Productive work**

These are services, which can be bought, sold, or exchanged in the market. The work involved here is producing goods and services and work is valued not based on merit, but based on gender. The work that a man does is considered productive by virtue of this definition and that of a woman is considered unproductive, and is therefore, not valued or is undervalued.

ii) **Reproductive Work**

There are two kinds of reproduction.

Biological reproduction

It refers to the sexual division of labour involved in reproduction.

Social reproduction

It refers to the woman's role in maintaining the productive roles of men. She is not earning, but she is producing the person who is earning. Rearing and bearing is reproductive function based on biology. Sustaining of all gender, irrespective of whether its male or female is social reproduction.

iii) Community work

This refers to the unpaid activities, which are necessary for the existence, sustenance and social cohesion of the community, e.g. conducting birthday parties, marriages, attending funerals, helping the needy, giving benefit to society without any profit motive, honorary work in a Housing Society, making a temple and other forms of social interaction which lead to building up of society. These roles are mostly performed by men, who are seen as community leaders.

Facilitators guidelines:

- There may be grey areas, but the division of roles must be clearly demonstrated based on stereotypes
- Encourage discussions on whether productive roles are possible without reproductive roles. E.g. Is it wrong for men to do housework? Do women cook because they have uterus?
- While guiding the discussions, do not make it a man vs. women issue. Emphasise the importance of sharing e.g maternity and paternity leave
- Introduce the concept of multiple roles of women (e.g. Balancing personal work and professional roles. How can imbalances be reduced?)
- Emphasise the importance of gender role analysis for gender sensitive planning of health services e.g. women's tune, mobility to decide to come to clinic etc.
- Circulate handouts 1 to 3

Further readings :

PAHO (WHO) facilitators guide on Gender, Health and Development.

Session IV (Day two) : INTRODUCTION TO ICPD, PRINCIPLES

60 minutes

Objective: To familiarise participants to the principles and programme of action of ICPD

Core message: Population stabilisation is seen in the larger context of gender and development. It is not the mere control of numbers; it is to do with improved quality of life. Participants are able to see the links between ICPD, POA and …

Expected Outcome: Participants are able to link the ICPD principles with policies and practices in the Health system.

Note to facilitators:

ICPD stands for International Conference on Population and Development held in 1994 at Cairo.

Facilitators guidelines:

- Use the presentation in Handout 4
- This may be transferred to transparencies before the start of the workshop
- Explain with the help of transparencies
- For more information go through the original ICPD, POA (Plan of Action)

METHODOLOGY: PRESENTATION

See presentation at Handout NO: 4

SESSION V : SOCIAL , ECONOMIC & CULTURAL DETERMINANTS OF WOMEN'S HEALTH

90 minutes

Objective: To understand the socio-economic & cultural determinants of women's health.

Core message: Gender is part of larger social issues.

Expected outcome: Participants will be able to outline the different socio-economic and cultural factors which affect the health of women

Methodology: Film Adha Asman (thirty-two minutes), content analysis discussions, web game.

STEP I

Brief the participants that they will be shown a film. The documentary film 'Adha Asman' was shot among the hill women of the present state of Uttaranchal. It talks about health burden of women, which is a result of perceptions of women's roles and responsibilities, poor self-image, social and cultural norms, lack of male participation and responsibility to sexual and reproductive outcomes. The title means "Half the Sky". Participants are asked to note down as many factors as they can, which affect women's health status while viewing the film.

Screen the film

After screening the film, the participants are asked to discuss the different socio-economic and cultural factors, which are responsible for women's poor health status. This process is called the content analysis through free flowing expression of reaction to the film. Some of these could be:

- Poverty
- Rituals (no bath, cow dung, 22 days)
- Early marriage

- Women's work load high, but think she can not do, multiple types of work, not valued, effect on health, no rest
- Men not sharing in labour or caring for her health
- No freedom to take decision – even to go to hospital or go alone. Dependence on man though she runs whole household
- Shy, shame, (sharam) lack of knowledge, information, awareness
- Discomfort to be tolerated : handle at home, no need to go to hospital
- Lack of sensitivity of service provider
- Hospital PHC far away
- Daughter not looked after, son preference – multiple pregnancy less FP
- Men resist women taking position of authority
- Women not supporting women
- Health service provider only sees what he/she needs from client, not what client needs
- Religious taboos
- Hospital badly managed : e.g. Ambulance
- Lack of hygiene
- Husband not there to share and care

Ask the participants whether the situation of women in their work area is similar to that of the women shown in the film. How is it different?

OR Step II (if film is not readily available)

The Web Game
(materials required- chord)

A case study on socio cultural determinants of women's health is given to the group. The facilitator reads out a story, stops at different points asking the participant to identify the cause of the situation mentioned in the case study at that point, giving the following five options:

- Sex

- Gender
- Social and cultural
- Political
- Economic

A strong chord held by the facilitator at the centre is moved to the participant who responds first and the chord is rolled over and fastened on the hands of the respondent. The chord is moved with each question and response, in a complex way, to the five corners \ themes and this becomes a web. More than one option was possible for each question. At the end of the case study, the facilitator standing in the middle, points to the area where there is the least and where there is the most grouping of participants. A maximum number is usually seen in the socio-cultural corner and least in the sex corner. Then the facilitator asks each participant to give one response, which could be an answer \ solution \ approach to the issue and then cuts the chord to release each participant.

LAKSHMI'S CASE STUDY

Lakshmi belongs to a village in central Tamil Nadu, located about 15 km from the district headquarters. She is 27 years old and is a Scheduled caste agricultural wage labourer.

Lakshmi grew up in another village. She was first of four surviving children, three girls and a boy. Her father had another woman. The family suffered a lot because of this. Lakshmi's mother had to go out and earn a wage. Lakshmi was stopped from school after Class 1. She would graze cattle and earn money, and when she was about 10, started working as agricultural labourer.

When Lakshmi was only 14, she was married to her uncle's son Ramu because there would be no dowry involved. Ramu was 25, and was also an agricultural wage labourer without any property.

When they got married, Ramu told Lakshmi that times had changed, and that they should have only two children. If they had a boy and a girl she should have an operation. But somehow, Lakshmi never conceived for two years. Her mother-in-law started abusing her.

She conceived when she was 17. Her first pregnancy was very difficult. Her arms and legs and even her face were swollen, and something would cloud her vision. She would also bring out everything she ate, day after day. But she never went to see a doctor. People said this is how it would be when you are pregnant. After her delivery of a baby girl, born in government hospital, all these problems went away.

The second baby was also born in hospital. But he died in a few days: vomited once in the morning, was taken to hospital immediately, but died. The third was a daughter, and she died a few hours after birth. Some doctors said the baby had a heart problem, others said that Lakshmi was very weak that is why, some others that it was because she had married a close relative. But the baby was very small and skin and bones. Lakshmi felt heart broken.

After her third delivery Lakshmi started having foul-smelling white discharge frequently. She did not do anything about it, telling herself that this must be because of weakness.

Lakshmi started a *'vrat'*, fasting once a week, for a healthy birth the next time. Her fourth baby was born recently, and is a boy. Lakshmi wanted to have a family planning operation, and so did Ramu. But the doctors said that she was too weak, and sent her home. They asked her to come back after her health had improved.

Lakshmi is desperate. She does not want to conceive immediately, and wants to make sure that her son survives and grows into a healthy child. But knowing her husband, she thinks abstinence is not feasible. She is afraid also that if she refuses, he will take another woman, just like Lakshmi's father did. She wants to know if we can help. Can we ?

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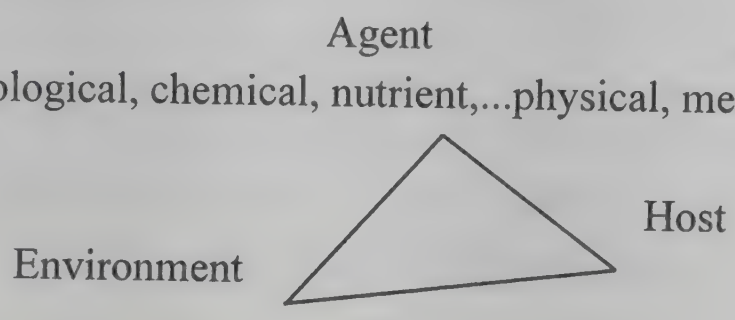
Ask the participants whether they as doctors consider all these socio-cultural factors when they are making a diagnosis/examination of a patient or giving her treatment? How does this framework for understanding women's health problem differ from the germ theory or the epidemiological triangle that they have learnt?

Note to facilitators

Doctors are usually taught different theories of understanding the occurrence of diseases. Two of the most popular theories of understanding diseases have been the germ theory and the epidemiological triangle. The main points of the traditional germ theory are

- Disease is caused by transmissible agents
- One agent causes one disease
- The main role of medical practice is the identification / control / elimination of the disease agent.

The epidemiological triangle explains multi factorial disease causation through a triangle viz. the agent, host and environments at the three vertices. An imbalance between the three causes disease.



Both the above theories are examples of the biomedical model as opposed to the socio-cultural disease causation perspective.

The bio-medical understanding/approach which is prevalent in medical thinking emphasises on the internal disease processes and attempts to understand ill-health through an increasing scientific understanding of disease-causing agents and the biologic responses (host). It is limited in its understanding at least on an operational level of social causes. It can be argued that host factors include literacy, poverty, beliefs and attitudes and environmental factors include access to food or health care services- but this is not the way these three factors are taught/interpreted in medical school. Since doctors are supposed to be experts in understanding the internal working of the body – both physiologically and pathologically, the emphasis remains on pathology, clinical signs and symptoms, internal investigations and finally therapy. In therapy too drugs pay a dominant part. Thus the social understanding of disease causation and the use of social tools in therapy have limited application in majority of medical practice as the situation is today in India.

A socio-cultural understanding on health on the other hand can use the same epidemiological triangle in a different way as illustrated above. In the socio-cultural approach/understanding of health and illness the factors which have been discussed in this session are examined closely for their correlation with health outcomes. It has been clearly established through many studies that these are as important as other biological factors in the health outcome of individuals and to address different illnesses it is essential to address these issues as well. Dealing many of these factors may be outside the skills or mandate of the practitioner, but the practitioner should be alive to these circumstances and do whatever little is possible to alleviate the problems of the patient and provide her with succor.

Notes for the facilitator

B. A Framework for understanding the socio-cultural and economic determinants of women's health are:

Women's Status in the Family and community

Women's status in the family and community determines their health status to a great extent. This includes the differential food allocation for girls and women, pressure to get daughters married off, differential educational opportunities provided to girls *vis- a-vis* boys and so on. Violence at home is also a product of gender relations. Women's ability to negotiate contraceptive use with husbands, the ability to negotiate the number of times she has to get pregnant, or the decision to abort a female foetus — all depend upon the power a woman has at home and in the family.

Religion

Religion is one of the main instruments which lays down how the followers should behave. It includes strict codes which are enforced on moral behaviours, bodily functions, contraception and so on. Many o these religious codes in many of the world's religions are detrimental to women's health and rights.

Traditions

Traditions are somewhat different from religion in the sense that traditional codes may not

be sanctified by religion, but they are equally strong and depend upon the region and local mythologies. Dietary practices and restrictions, on the mobility of women and age at marriage, are instances of traditions that have great implications on women's health.

Educational Status

The impact of women's educational status on maternal health and child survival was being studied by demographers in order to understand whether the goal of population stabilisation is easier to achieve with an educated group of mothers. Similarly, it is an established fact the health of women is profoundly affected by their level of education.

Poverty

Poverty is a very important determinant of women's health. This is not only the general poverty of the whole family but also the relative poverty of women within the household. Women have much less access to and control over economic resources, and this makes them the poorest of the poor. Poverty affects birth conditions and outcomes, health status in childhood, social status, educational status and so on. Women do most of the housework, which is unpaid. Thus their economic contribution is undermined. And when it comes to the right to food, money for medicine, rest, and so on within the family, women do no get these on priority. Sanitation and personal hygiene, two very important determinants of women's health, again depend upon the economic situation of the woman. The long and arduous work hours of women affects their mental health as well. Economic vulnerability often forces women into accepting situations of violence and unsafe sex.

Environmental degradation, workload and women's health

Environmental degradation is the reality in most of world's poorer nations and also in India. This degradation of the environment is linked with the workload of women, and has serious effects on their health. All over the world and in India, women have the lion's share of domestic workload in economically weaker sections and rural communities. Rural lifestyle is heavily dependent on natural resources. Forests provide timber, firewood, leaf-litter, and even the supply of water is dependent on forests. The fields also produce fodder and kindling in addition to crops. Cow dung is jealously collected as an important source of fuel. And the collection of all these is primarily the task of women. With increasing deforestation and environmental degradation, these resources are getting scarcer and the task for women is getting harder. Even advanced farming technology is reducing some of these natural products

– for example crop residue, cow dung and this leads to an increased burden on the poor woman to arrange for substitutes.

The increased workload of the poorest women contributes to a great extent to her health status. Due to a lack of time, she often does not have the time to look after herself- even in terms of the time for bathing and attending to personal hygiene. On the other hand, she also has to suffer conditions such as miscarriage, generalised weakness, body aches and joint pains, uterine descent and so on. It goes without saying that her nutritional status is also affected.

Gender-based violence

It is important to consider the importance of violence as a determinant of women's health. Women are exposed to a continuum of violence right from the time they are conceived. This violence takes place in all spheres of her life — at home, at the work place, in the community and, of course, in situations of conflict. All these types of violence against women are linked to the same familiar causes: their lower social status, the notion that women are the 'property' of men, and that it is acceptable for men to exercise control over them, by whatever means.

Domestic violence

This violence against women has been called the 'hidden epidemic' because of its prevalence. But there is a reluctance to take action against such violence when it takes place in the privacy of the home. But the statistics gathered over the last decade or so have brought to light how widespread it is and how profoundly it affects the health of women. Domestic violence includes battering, rape, sexual abuse, even burning and homicide. The physical and psychological consequences of such violence is serious physical trauma, pelvic pain, miscarriages, burns, attempted suicides, depression and other psychiatric morbidities.

Unfortunately, most health systems and health planners at all levels have been slow to respond to this 'hidden epidemic' and do not consider this a health issue at all. Women's health activists in many countries demand that the health sector:

- Regard domestic violence as a public health issue;
- Undertake more specific research on its causes, consequences and methods to prevent it;

- Disseminate information about domestic violence to health workers or conduct training to strengthen their ability to recognise signs of domestic violence.

Violence in displacement and conflict situations

Women are especially vulnerable in situations of armed conflict or mass population movement. Women are forced to leave their homes as refugees and are often separated from the men in their families, and have few means to protect themselves from violence. Armed conflicts use women's bodies as battlefield in their struggle for power and are, therefore a political phenomenon. Sexual assault against women is seen as a victory over the enemy. Thus, all situations of armed conflict leave women vulnerable to sexual exploitation and sexual violence, which may lead to physical injury, unwanted pregnancies, RTIs and STIs and, of course, the whole range of mental and emotional consequences.

Many of the so-called life-style diseases where poor women are concerned are due to her social status, the religious and cultural traditions that she has to follow and the nature of her work and the workload.

SESSION VI : REPRODUCTIVE HEALTH AND GENDER

120 minutes

Objective:

- To understand the concept of Reproductive Health and to what extent these services are being provided in the Health systems
- To understand the differential RH needs of men and women

Core message: All reproductive health issues have a gender base

Expected outcome: Participants analyse gender implications of each component of RH

Methodology: Group work, Presentation, Discussions

STEP I

Ask the participants what they mean by the term reproductive health, and how is it different from the earlier term of Family Planning. Define RH on the basis of the ICPD definition and try to explain its components and highlight the differences.

What is RH?

A Reproductive health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable, and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility... and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and child birth and provide couples with the best chance of having a healthy infant.

—ICPD, Cairo

Note to Facilitator:

Some of the differences between the FP approach and the RH approach are

- Range of services is more comprehensive
- Includes a rights based approach
- Acknowledges the health needs of women
- Is based on a life cycle approach
- Is based on the needs of the individual (women)
- Talks of quality services
- Includes counseling as an essential part of services

STEP II GENDER ANALYSIS

Based on the previous sessions understanding, ask participants whether they would like to take up each component of RH and see how they get affected by gender issues. Explain that although communicable diseases are not part of RH, gender analysis of TB, leprosy, etc. could also be done. Now divide the participants into groups and provide them a gender analysis of any one condition – RH or other wise. Then ask the groups to do a gender analysis of any one RH condition- e.g. FP, Infertility, Abortion, STD/HIV-AIDS, Antenatal care etc. The following format is useful for doing gender analysis.

Issue	Men	Women
Biological causes		
Symptoms and manifestations		
Social vulnerabilities causes		
Roles and behaviours		
Response of self		
Response of the family		
Response of the health system		

After each group has made its presentation-complete the analysis either through discussion with your inputs.

A sample is worked out for guidance of the facilitator. The sample relates to gender analysis of RTI\STDs

ISSUES	MEN	WOMEN
1. Biology & Causes	• Anatomy of the sexual organs. • Less exposed surface area.	• Anatomy of sexual organs. • More exposed surface area. • Fluid retention and retention time. • Close proximity of urinary tract. • More prone to sexual injuries. • Mucous membrane widely exposed to infection. • Infection leads to chronic infection.
2. Symptoms & manifestations	• Ulcers • Chancroid • Lymphadenopathy • Urethral discharge • Urinary symptoms • Infertility • Systemic infection	• White discharge • Abdominal pain • Pus discharge • Burning and itching • Menstrual abnormality • Ulcer / frequency of micturition • Lymphadenopathy • Infertility
3. Social caused & vulnerability	• Heterosexual behavior • High risk behavior • Migration • Personal Hygiene • Family separation • Easy availability of Condoms • Economically self dependency (medicines etc.) • More faith on quacks • RTI/STD is considered an outcome of some super natural power. • Lack of knowledge	• Unsafe sex • Prostitution • Rape • Personal Hygiene • Poverty • Illiteracy • Lack of female health service providers • Lack of privacy • Shyness and tendency of hide • It is considered normal • Lack of knowledge
4. Roles & behaviors	• Active partner • Decision maker in contraceptive usage • Psyche. Behavior	• Passive partner • Cannot impose her choice. • Behavior (Psyche.)
5. Response of self	• No delay in treatment • Search of a virgin for treatment (myth)	• Tendency to hide • Delays in treatment • Hitch in going to male service providers
6. Response of family	• Caring and sympathetic	• Blame of having extra marital affairs • Blame their parents
7. Response of health provider of health system	• Treatment • Counseling • Insufficient service providers medicines and para-medical staff (trained)	• Scolding • Blaming • Judgmental • Insufficient service providers medicines and para-medical staff (trained)

Facilitators guidelines.

Once the presentations by groups are over, supplement from the handout made on each RH issue.
Handouts No: 5-8

SESSION VII : GENDER - BASED VIOLENCE AND RH

120 minutes

Objective: To understand gender-based violence its impact on RH and the potential roles of providers in addressing it through the health systems.

Core message: Positive role of providers in addressing gender based violence.

Expected outcome: Establish linkages between RH and gender-based violence in concept and practice

Methodology: Film show, discussions, case study, group work.

STEP I

Brief the participants that they are going to see a film on gender based violence and screen Nasreen O Nasreen.

After the film show ask the participants how they ***Feel*** after seeing the film. Do not comment on anyone's feeling and do not allow any discussions on the feelings. How many types of gender based violence do we come across in the film. Can the participants mention other types that they may have heard or come across. (An indicative list is given below:

- **Physical/mental torture.**
- **Verbal, sexual and physical abuse.**
- **Eve-teasing (man to girls/women.)**
- **Sati.**
- **Public insults.**
- **Not paying attention to her, confining her.**
- **Neglect of her medical nutritional, educational and personal needs.**
- **Non-co operative behaviour.**
- **Compelled to follow social traditions (Devadasi).**

- **Sexual harassment.**
- **Extra-marital relations**
- **Divorce without reason/threats of divorce.**
- **Comparing.**
- **Demanding dowry.**
- **Abetting suicide.**
- **Not calling wife back from the natal home.**
- **Selling one's wife.**
- **Forcing wife/daughter into prostitution.**
- **Procuring of mental derangement.**
- **Witch-hunting**
- **Foeticide /infanticide.**
- **Rape, illegal pregnancies.**
- **Marital rape.**
- **Unwanted examination.**
- **Verbal abuse (words in the health system).**
- **Abandonment and exposure**
- **Coercive sterilisation (case of quinacrine).**
- **Unnecessary hysterectomies/c-sections.**
- **Induced abortion.**
- **Black mailing with photographs.**
- **Unnecessary drugs.**
- **Abduction.**

Do the participants think that gender based violence is a common phenomenon? Are there any health consequences of gender based violence? List the health consequences of Gender Based Violence.

Note to Facilitator

- Violence is a human rights issue. All forms of violence should be condemned. But documented evidence shows that women are more subjected to violence by men, as violence is a way of maintaining and reinforcing women's subordination.
- Women commit violence against women also e.g. mother-in law on daughter-in law for dowry is common. This also is made possible because, women use the authority of being son's mother to enforce her domination.
- Explain physical and mental health consequences of violence, which is usually not recognised such as,. Post-traumatic stress, Eating disorder, Depression, Anxiety, Sexual dysfunction, Low self-esteem, Phobias
- Providers can do their jobs well if they understand how violence and powerlessness affect women's reproductive health and sexual decision making ability.
- RH care providers are strategically placed to identify victims of violence and connect them with other support services. (Medico legal or medico social)
- 90% of domestic abuse, with or without visible violence require medical, psychological, public health treatment.
- Women are far more likely to reach the health system/ professional first than to police, lawyer, media etc.

STEP II

Impact of gender-based violence on women's health/RH.

Ask the participants to think of examples linking violence with RH outcomes. Guide the participants, and help them to see the connections with one or two examples and then add to the following list. Encourage participants to share real life examples

- Impact on perinatal health
- Unwanted pregnancy/abortion
- STIs / HIV through consensual sex or by inability to negotiate contraceptive use

- Pelvic problems
- Miscarriage

STEP III

ROLE OF HEALTH SYSTEMS

Ask the participants how they would deal with a case of violence. Note their response and add to what they say from the following:

- Identifying women experiencing abuse by being alert to the possibility of violence.
- Connecting them with support systems/resources.
- Documenting and monitoring extent and nature of violence
- Integrate violence into the public health agenda.
- Morbidities, Mortalities and Fatalities can be reduced by proactive work
- Link with the police and health system.

Ask the participants (in groups if time permits) to react to the situations given below:

Sample case studies

i) A woman in her reproductive age has TB of the lungs. She has 3 daughters and is harassed and ill-treated for not being able to produce a boy. She is very weak. She wants to use contraceptives without the knowledge of her husband.

ii) A woman comes with an injury on her forehead. She is married for 16 years and has not produced a child, so far. The husband has come to the doctor with her and does not leave her side. Past records show that she suffers from hyperacidity.

Note to Facilitators :

Recognise the problems health providers face in addressing violence. However, guide the discussion.

- Time constraint
- Cultural reasons
- Unsure of support in the health systems
- Private issue
- Poor interpersonal communication
- Gender bias
- Male domination in hospitals
- Clients also don't see it as a problem
- Bio-medical approach

Encourage participants to share, if they have done something in their workplace to address violence.

WHAT NOT TO DO

- Violate confidentiality
- Trivialise the views
- Being judgemental
- Blaming the victim
- Not respecting her autonomy
- Normalising victimisation
- Ignoring her need for safety plan

Safety Plans

1. Acknowledging the violence
2. Danger assessment/Risk factors
3. Identifying allies/Referrals liaison with community
4. Considering options for children
5. Developing a strategy for escape

Circulate handouts No: 9, 10, 11, 12 & 13

SESSION VIII : MALE PARTICIPATION

120 Minutes

Objective: To highlight the importance of male participation in RH.

Core message: RH programmes make positive and substantial gain through male participation.

Expected outcome: Participants learn ways of facilitating male participation into RH programmes.

Methodology: Film show, group work and discussion (from the serial *Pukar*)

STEP – I

Show the participants a ten minutes excerpt from the film on male participation from the series Pukar. After the film-show ask the men what they saw in this film which is different from real life and how. (The participants will make a list of the domestic roles that the man performs and the roles that the woman performs) Ask how many participants disagree with what is happening in the film? Why doesn't this happen in real life? If it happened what difference would it make – to men and to women? Sum up the discussion by focussing on partnership between men and women based on shared commitment.

Brief of the Film

In this film, the woman is shown as the provider and the spouse plays a role of a home maker. They have a very good understanding of each other until .....

OR STEP – II, If film is not available

Divide the participants into groups and give them the question "How can partnerships be promoted for improving women's reproductive health – what can men do in Pregnancy/ RTI-STDs/Infertility/Family Planning/Safe delivery Etc." Each group can be given one topic to discuss. Ask the discussion to focus on concrete steps that can be taken at the family level (as father/brother/husband/father-in-law, etc.), at the community level and at the health service level.

Ask each group to make their presentations and add if and where necessary.

Ask participants to narrate their experiences on involving males in their work

Facilitators guidelines – Examples of male participation in RH
(Note: All may or may not be possible to apply by MOs or at MOs level)

- Increase Vasectomy services and use of condoms
- Paternity Leave
- Male *goshthis* (group meetings in the community)
- Involving men in pre and post natal care in clinics
- Joint counseling of couple in safe motherhood or other reproductive processes
- Increasing male presence at the time of delivery
- Services must be available outside of normal working hours
- Talk about adoptions in cases of infertility
- Increase & diversify role of male health workers
- Remove stereo-types (e.g. only male to do post-mortem)

Facilitators guidelines

- Caution must be taken not to position this as a male versus female issue
- Male participation must be explained not from the context of contraceptives, RH alone but from the perspective of gender relations \ gender cycle.
- The examples of male involvement given above may not all be applicable to MOs levels. Some may also be possible as individual responses, some as professional responses

SESSION IX : HOW TO PROVIDE GENDER SENSITIVE HEALTH SERVICES

90 minutes

Objective: To understand applications of gender sensitive health service

Core message: Providers roles can make a great difference despite constraints to health seeking behaviour of men and women.

Expected outcome: Participants learn practices relating to gender sensitive provisions of health services.

Methodology: Role Play, discussions

STEP I

Divide the participants into three or four groups and each group is given one situation to enact. The situations are like this - A woman has an RH problem and comes to see a provider (a different RH problem for each group) – Enact a play in three scenes – one of her home, one at the clinic and one with the doctor in his Health Manager's role. The play has to incorporate the following – social cultural determinants of health, qualities of a sensitive provider, male participation, and systemic gender sensitive response.

While the plays are being enacted the audience is asked to note how a gender sensitive health service is being demonstrated while noting the following:

Attitude, Range of services, service delivery environment, and quality of service.

After the plays have been enacted ask the participants who were the viewers to note their observations. The participants are asked to critique the process and contents of role play. The debriefing and consolidation can use this framework for reviewing what is shown in the role-plays.

Attribute	Positive aspects	Aspects that need to be improved
Attitude of the providers		
Service delivery environment		
Quality of services		
Range of services		

STEP II

On the basis of the above observations prepare a list of indicators for gender sensitive health services. The indicators should be simple, easily do-able and if possible it should also be documented.

RH services	Indicator of gender sensitive services
FP/Contraception	
MCH	
RTI/STI etc…	

Facilitators notes :	
Attribute	What we can do
Attitude of the providers	Respect for the patient Patience Asking relevant questions, listening carefully to answers Taking detailed background history No scolding, blaming Healing touch No advice before hearing what the patient has to say
Service delivery environment	Providing confidentiality, Clean and comfortable Waiting area, bathroom, curtained examination table

Quality of services	Helpful attitude of all personnel Provide clear and specific directions Practical advice, provide examples Doctor provides a role model Treat both husband and wife when necessary No hurry Timings suit the patient
Range of services	Appropriate and affordable treatment Prescribed range of drugs and equipment available and used All personnel available as per norms

A list of possible indicators for gender sensitive RH services

FP/Contraception

- No. of condom users as a ratio of IUD and oral pill users
- No. of vasectomies as a ratio of number of tubectomies
- Sex ratio of births
- Average spacing between two children
- Age of mother at first child birth

RTI/STD

- No. of couples with RTI/STD attending OPD
- No. Of unmarried women with RTI attending OPD

MCH

- Sex disaggregated IMR
- No. of husbands counselled for wife's ANC, Safe deliver and for Family Planning

Adolescents

- No. of adolescent patients attending OPD – Male and Female
- No. of adolescents counselled at OPD – Male and female
- No. of health talks given to schools (boy and girls) by health worker

Gender based Violence

- No. of MLC with analysis of causes (both for male and female)
- No. of Gender based violence cases identified in OPD

Infertility

- No. of infertile couples counselled
- No. of males seeking treatment/investigation

SESSION X : POPULATION MYTHS AND FACTS

90 minutes

Objective: To review if all the previous sessions have resulted in understanding population issues from a gender perspective.

Core message: Facts and figures demonstrate based on experiences in India and clearly that population stabilisation comes with development and not through control.

Expected outcome: Participants are able to segregate facts from myths on population issues.

Methodology – Presentation

Facilitator's guidelines

- Make transparencies from the presentation given in handouts 14.

Evaluation of the Training

POST WORKSHOP QUESTIONNAIRE

Time 15 minutes

1. Name of the participant :

2. To what extent do you think your expectations of this workshop have been met? Rate on a scale of 1 – 10 where 1 is not at all and 10 is entirely.

3. What were your three major learnings from this workshop?

4. How do you think this workshop will make you a better service provider?

5. What kind of changes would you like to bring about in you personal and professional behaviour?

   Personal

   Professional

6. What kind of follow-up support would you need/want for implementing the learning from this workshop (Please be as specific as you can)

7. What in your opinion could be done to make the workshop more effective?

8. Should workshops like these be held on a regular basis? Give reasons for your answer

9. Do you think gender is linked with reproductive health? Give reasons for your answer.

10. Do roles and norms for men and women determined by society affect men? Give reasons for your answer, and provide examples to illustrate your answer.

11. Caring for children is women's responsibility? Agree/disagree

12. There are more men leaders in society because women lack leadership qualities. Agree/ disagree

13. Societal norms for men and women are appropriate Agree/disagree

14. All diseases (except gynaecological diseases) affect men and women similarly. Agree/ disagree

15. Men have more knowledge mainly because they have more exposure to the world. Agree/disagree

16. Comment on the trainers.

Name

Co-ordination

CLARIFYING RELATED CONCEPTS

Some underlying concepts involved in gender training requires to be explained for trainers. Trainers would need to explain these when required.

Sex and gender

Sex refers to the biological differences between men and women.
Gender refers to the roles that men and women play and the relations that arises out of these roles. They are socially constructed, not physically determined

Access and control

Access is the ability to use a resource
Control is the ability to define and make binding decisions about the sue of a resource

Practical and strategic gender needs

Practical gender needs	**Strategic gender needs**
Short term needs	Long term needs
Needs more easily identifiable	Needs less immediately identifiable
Biological requirements and specific health conditions	Targets inequities in power relationships
Provides health goods and services	Focuses on empowerment processes viz. Self-esteem, creation of awareness
Involves men and women as passive subjects	Involves people as active participants
Improves health conditions	Improves position of women to increase access and control over resources
Gender roles and relations remains constant	Improves balance of power relations between men and women in the use of health resources, through control over internal and external factors that affect ability to protect health

Sexual and gender division of labour

Sexual division of labour is nature's way of assigning roles and responsibilities. Woman reproducing and breast feeding the baby and man inseminating is sexual division of labour Gender division of labour arises from the social construct of what woman/man should do and should not do. It is assigned not based on merit, but based on gender.

Production, Reproduction

From sexual and gender division of labour, we derive the definitions of production and reproduction. Productive comprises the work done by both men and women for payment in cash or kind

Reproductive comprises child bearing/rearing responsibilities and domestic tasks. It includes tasks done to reproduce society, both physically and through passing on its systems and values

Community management roles comprises activities undertaken at the community level to contribute to the development or political organisation of community and is, usually, paid or voluntary work

Patriarchy and Matriarchy

They mean male and female domination respectively, in very simple terms. But there are related terminologies which must be explained to avoid any confusion on the understanding of these terms.

Inheritance of property	**Patrilineal**, Where male inherits	**Matrilineal**, Where female inherits
Residence on marriage	**Patrilocal**, Where wife lives in husband's home	**Matrilocal**, Where husband goes to live in wife's home on marriage
Decision-making	**Patriarchal**, Where all decisions rests on males. Women have decision-making to the extent that they accept the rule of patriarchy	**Matriarchal**, Where all decisions rests on females. But even here they don't control other social institutions.

Empowerment

It is a process whereby individuals develop strength and skills to act towards personal and collective good.

Gender-based violence

Any act of gender-based violence that results or is likely to result in physical, sexual or psychological
harm or suffering, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or in private life

Male participation

It means providing the enabling environment for existing and changing needs and concerns of men depending on gender relations, which would help both men and women in the context of Sexual and Reproductive health (SRH)

Sexual and gender division of labour

Sexual division of labour is nature's way of assigning roles and responsibilities. Woman reproducing and breast feeding the baby and man inseminating is sexual division of labour
Gender division of labour arises from the social construct of what woman/man should do and should not do. It is assigned not based on merit, but based on gender.

Equity and Equality. (Samata and Samanta)

EQUITY	**EQUALITY**
Fair	Equal
Not measurable and quantifiable	Measurable and quantifiable
Subjective and can change with culture, community, society	It is a universal goal
Positive discrimination through reservation	No such concept
Practice	Principle

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Percent distribution of ever-married women by person who makes specific household decisions, according to residence, India, 1998 – 99.

Household decision	Respondent only	Husband only	Respondent with husband	Others in household only	Respondent with others in household	Missing	Total percent
URBAN							
What items to cook	71.3	3.5	4.7	10.2	10.5	0.0	100.0
Obtaining health care for herself	35.0	34.2	17.7	7.0	6.2	0.0	100.0
Purchasing jewellery or other major household items	13.3	28.5	35.7	11.1	11.4	0.0	100.0
Going and staying with her parents or siblings	18.0	36.3	28.4	9.0	8.2	0.0	100.0
How the money she earns will be used[1]	57.0	14.2	24.0	1.9	2.8	0.1	100.0
RURAL							
What items to cook	71.1	3.7	4.3	11.6	9.3	0.0	100.0
Obtaining health care for herself	25.7	41.1	16.7	10.0	6.6	0.0	100.0
Purchasing jewellery or other major household items	9.7	35.7	29.2	14.4	11.0	0.0	100.0
Going and staying with her parents or siblings	12.4	41.2	23.9	13.0	9.4	0.1	100.0
How the money she earns will be used[1]	36.5	31.0	25.3	3.5	3.6	0.2	100.0
TOTAL							
What items to cook	71.2	3.6	4.4	11.2	9.6	0.0	100.0
Obtaining health care for herself	28.1	39.3	16.9	9.2	6.5	0.0	100.0
Purchasing jewellery or other major household items	10.7	33.8	30.9	13.5	11.1	0.0	100.0
Going and staying with her parents or siblings	13.9	39.9	25.1	12.1	9.1	0.1	100.0
How the money she earns will be used[1]	41.1	27.2	25.0	3.1	3.4	0.1	100.0

[1]For women earning cash

Source: NFHS – III, 98-99

Women's autonomy

Percentage of ever-married women involved in household decision-making, percentage with freedom of movement, and percentage with access to money by selected background characteristics, India, 1998 – 99.

Background characteristic	Percentage not involved in any decision-making	Percentage involved in decision-making on:				Percentage who do not need permission to:		Per-centage with access to money	Number of women
		What to cook	Own health care	Purchasing jewellery, etc.	Staying with her parents/ siblings	Go to the market	Visit friends/ relatives		
Age									
15 – 19	24.4	66.6	38.6	39.8	37.4	13.8	10.2	45.5	8,182
20 – 24	15.4	77.3	45.0	46.1	43.1	22.0	16.6	54.1	16,389
25 – 29	9.4	84.9	49.7	51.5	46.2	28.8	21.1	58.8	17,745
30 – 34	6.1	89.4	53.6	54.8	49.3	34.0	25.1	61.1	15,094
35 – 39	4.8	91.9	56.5	57.7	52.7	37.9	29.8	64.3	13,089
40 – 44	3.7	92.6	59.3	59.3	53.6	43.0	35.1	65.9	10,521
45 – 49	3.9	91.6	60.1	60.3	56.1	45.4	37.5	67.6	8,179
Residence									
Urban	7.1	86.3	58.9	60.4	54.6	46.9	35.0	73.6	23,370
Rural	10.3	84.7	49.0	49.9	45.7	26.1	20.6	54.6	65,829
Education									
Illiterate	9.6	86.1	48.6	49.6	45.1	27.0	21.6	52.8	51,871
Literate, < middle school complete	9.1	85.2	52.5	54.0	49.2	32.6	24.3	61.3	17,270
Middle school complete	11.3	81.6	53.5	54.3	49.7	35.9	25.6	66.6	7,328
High school complete & above	8.1	83.3	61.2	62.0	57.2	46.2	35.0	81.0	12,719
Religion									
Hindu	9.6	85.2	50.8	52.4	48.0	31.8	24.6	59.4	72,903
Muslim	10.7	82.8	50.5	48.1	43.4	23.4	19.0	56.0	11,190
Christian	5.8	88.0	63.0	65.6	61.7	44.6	35.6	68.5	2,263
Sikh	2.4	93.6	74.6	72.5	64.6	46.2	25.6	74.0	1,427
Jain	9.8	84.3	54.7	55.9	47.0	50.9	39.8	74.0	331
Buddhist/Neo -Buddhist	4.6	89.7	57.0	58.7	52.7	56.3	38.7	72.2	676
Other	4.9	89.1	52.8	61.7	58.4	33.3	31.0	60.6	285
No religion	4.2	91.2	64.6	65.4	71.9	41.5	33.8	72.3	44
Caste/tribe									
Scheduled caste	9.1	86.2	49.7	51.8	47.4	31.3	23.7	56.0	16,301
Scheduled tribe	7.6	87.6	49.8	52.9	48.8	30.7	26.2	50.7	7,750
Other back-ward class	10.2	84.4	51.3	52.5	48.4	34.7	26.6	62.4	29,383
Other	9.3	84.7	53.3	53.3	48.2	29.6	22.7	61.0	34,904
Cash employment									
Working for cash	5.7	89.8	57.0	59.6	54.6	41.4	33.2	64.7	23,391
Working but not for cash	10.2	85.1	46.5	47.1	43.1	26.4	21.4	50.6	11,519
Not worked in past 12 months	10.9	83.1	50.3	50.8	46.3	28.5	21.2	59.3	54,271
Standard of living index									
Low	8.5	87.7	48.5	49.9	45.5	28.5	23.0	52.1	29,033
Medium	10.2	84.3	50.8	51.6	47.2	30.0	22.8	58.1	41,289
High	9.3	82.9	58.4	59.6	54.5	40.1	30.2	75.1	17,845
Total	9.4	85.1	51.6	52.6	48.1	31.6	24.4	59.6	89,199

Source NFHS - II, 98-99

How Burdened is Women's Life!

Weekly average time spent (in hours) on some peculiar activities by sex (All)

Activities	Haryana		Madhya Pradesh		Gujarat		Orissa		Tamil Nadu		Meghalaya		Combined states	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Cooking	0.36	11.37	0.62	14.24	0.38	13.85	0.86	19.28	0.38	14.74	1.06	13.74	0.52	14.93
Cleaning household	0.12	4.37	0.28	4.44	0.16	5.06	0.15	3.72	0.26	4.80	0.35	3.26	0.21	4.55
Cleaning utensils	0.10	4.68	0.13	3.71	0.10	4.28	0.10	2.45	0.06	2.62	0.82	3.90	0.10	3.39
Washing and Mending clothes	0.09	4.02	0.28	2.12	0.11	4.03	0.13	1.05	0.21	2.81	0.37	3.10	0.18	2.71
Shopping	0.39	0.34	0.64	0.31	0.45	1.56	1.03	0.23	0.48	0.50	0.40	0.44	0.59	0.64
Pet care	0.01	0.02	0.08	0.10	–	0.02	0.01	0.04	0.01	0.03	0.02	0.05	0.03	0.04
Care of children	0.18	3.91	0.26	3.23	0.33	3.25	0.53	3.92	0.29	2.36	0.47	4.44	0.32	3.16
Teaching own Children	0.08	0.18	0.14	0.10	0.17	0.33	0.27	0.18	0.11	0.18	0.35	0.29	0.16	0.19
Accompanying Children to places	0.03	0.06	0.23	0.21	0.02	0.04	0.02	0.02	0.05	0.09	0.05	0.23	0.08	0.09
Care of sick and elderly	0.06	0.11	0.02	0.12	0.04	0.16	0.10	0.54	0.01	0.08	0.03	0.19	0.04	0.19
Supervising children	0.12	0.89	0.25	0.96	0.51	1.13	0.24	0.54	0.16	0.45	0.98	1.79	0.28	0.78
Care of guests	0.14	0.04	0.01	0.01	0.04	0.11	0.04	–	0.02	0.02	0.15	0.24	0.03	0.04

Note: 1. The entry '–' in a cell indicates that no corresponding observation was found in the sample.

2. M : Male; F : Female

Source: NFHS – II, 98-99

WHAT WAS NEW ABOUT ICPD

1. THE WAY IT VIEWED WOMEN

IN THE DEMOGRAPHIC APPROACH

- Women were the tools through which population control objectives were achieved
- Control women to control population

IN THE ICPD APPROACH

- Women are intrinsically valuable
- Genuine concern about their health and wellbeing
- Empower them to exercise autonomy
  - on Reproductive Health and sexual health matter
  - within the context of social, economic and political situation
- Women's health not defined by access and availability alone but by their status in society- role of health seeking behaviour

2. THE WAY IT VIEWED FAMILY PLANNING

IN THE DEMOGRAPHIC APPROACH

- FP was the main tool for controlling population growth
- Effective methods received more emphasis
- Availability and access were the main concern

IN ICPD

- FP is a not the tool for population stabilization
- Client convenience and acceptability are as important as effectiveness
- Quality of service is as important as availability

3. ICPD MOVED TO REPRODUCTIVE HEALTH

- Acknowledged needs Meeting client needs became an important perspective
- beyond FP
- Therefore talked of addressing reproductive health concerns, not just FP
- RH/FP should not be a "women's only" problem. Men should not only share the burden of contraception, but should also be encouraged to be responsible and supportive partners

WHAT IS RH?

Reproductive health is a state of complete physical, mental and social wellbeing, not merely the absence of disease ... in matters relating to the reproductive system...

- Implies a satisfying and safe sex life
- Capability to reproduce, and the capability to decide if, when and how often
- to be informed and to have access to safe, effective, affordable and acceptable methods of FP
- Safe pregnancy and child birth, and a healthy infant

Sexual health is not merely counselling and care related to reproduction and STDs, but the enhancement of life and personal relationships

- Life Cycle Approach

- **The Beijing Women's Conference reiterated what ICPD said on RH and RR**

4. THE WAY ICPD VIEWED INCENTIVES & TARGETS

ICPD said ...

- Governments ... should use the full means at their disposal to support the principal of voluntary choice in Family Planning". (7.15)
- Governments ... are urged to institute systems of monitoring ... with a view to detecting, preventing and controlling abuses by FP managers and providers ... to ensure .. quality of services" (7.17)
- Governments should secure conformity to human rights and to ethical and professional standards in the delivery of FP and ... RH services aimed at ensuring responsible, voluntary and informed consent...." (7.17)

Government goals for FP should be defined in terms of of unmet needs for information and services. Demographic goals, while legitimately the subject of government development strategies, should not be imposed on family planning providers in the form of targets or quotas for the recruitment of clients" (7.12)

- Over the past century, many governments have experimented with ... schemes [of incentives and disincentives], in order to lower or raise fertility. Most such schemes have had only marginal impact on fertility and in some cases have been counterproductive". (7.12)
- Governments are encouraged to focus most of their efforts [for reducing fertility] ... through education and voluntary measures rather than schemes involving incentives and disincentives". (7.22)

5. ICPD WAS ABOUT DEVELOPMENT, TOO

ICPD remphasized the need to recognise Development as a key to achieving population stabilization objectives

- Positioned Development as a Right
- Income and Elimination of Poverty
- Eliminating Discrimination against women
- Education
- Preserving the environment

(Don't pin your hopes on FP alone)

PROGRAMME OF ACTION

	CHAPTER
Preamble, Principles	**1, 2**
Development	**3**
Gender, Health, Education & Family	**4, 8, 11, 5**
Reproductive Health & Rights and Family Planning	**7**
Growth & Structure, Internal and International, Migration	**6, 9, 10**
Action – National, International, NGOs & Pvt. Sector	**13, 14, 15**

6. ICPD INTRODUCED THE CONCEPT OF REPRODUCTIVE RIGHTS

WHY DO WE TALK ABOUT RIGHTS, WHY NOT NEEDS?

- Rights are Needs
- Codified as legal norms
- Not only to protect violation of rights
- But also to take positive actions to ensure they can be enjoyed
- Provider duties are the flip side of client Rights
- Rights will not exist without needs

June 15, 2001

REPRODUCTIVE RIGHTS INCLUDE

Reproductive Decision Making

- Voluntary choice in marriage and family formation
- Decide number, spacing, timing of children, and have the information and the means to do
- Access to safe contraception, good information, follow up

Sexual and Reproductive Security

- Freedom from sexual coercion and violence
- The Right to Privacy

Safety

- In childbirth, from infections : STD, RTIs, HIV/AIDS

June 15, 2001

REPRODUCTIVE RIGHTS INCLUDE (CONTD)

Valid for couples and individuals

→ Equity and Equality for men and women, exercising choices free from discrimination based on gender

→ Create an environment where people can freely make reproductive choices and decisions; invest in basic social services, education, and health care

June 15, 2001

WHAT HAPPENED AT ICPD + 5

June 15, 2001

- Gave more priority to tackling maternal mortality and morbidity
- Gave more priority to tackling HIV/AIDS
- Moved forward on Abortion :

ICPD :

Abortion not a method of FP;

Avoid abortion by providing FP

Deal with consequences of unsafe abortion

Where it is not against the law, it should be safe

ICPD+5 : Where legal services for safe abortion must be accessible, and provided in an environment that enables women to use them effectively. Train and equip health service providers

June 15, 2001

- Moved forward on adolescents :

Respecting rights, duties and responsibilities of parents but also the adolescents' need for confidentiality, privacy informed consent and respect for their evolving capacities and for their cultural values and religious beliefs and

- Made reference to widening the range of methods
- New benchmarks
- Need for partnership with NGOs, private sector, others
- Need for resources

June 15, 2001

TO RECAP

ICPD was :

about Development
about Women's Equality
about RH instead of FP
about Informed Choice
against coercion

Gender Issues - ADOLESCENT YEARS

- For girls, this is the period when numerous restrictions on their mobility begin to operate.
- Both girls and boys do not have access to information on sexual development and sexuality
- While girls are not encouraged to know about their bodies and about reproduction till they are married, gender norms expect boys to be sexually experienced well before marriage.
- Reproduction related risks increase because:
  - Trend towards lowering age of menarche
  - Increasing urbanization and exposure to mass media, making premarital sex more permissible in the minds of adolescents
  - Greater opportunities for premarital sex
  - Strict segregation of sexes together with expectations that young men should be sexually experienced encourage risky sexual behavior on the part of many young men.
- Lack of information about their bodies creates undue anxiety in boys on matters related to sexuality. For girls, lack of information on menstrual hygiene and beliefs and practices surrounding menstruation are important problems.
- Although exposed to sexual intercourse, access to contraception and to MTP very difficult for unmarried adolescent girls because of provider bias. This puts unmarried adolescents at risk of illegal, unsafe abortions.
- STDs and HIV/AIDS are globally second most prevalent in 15 –19 age group.
- 36% of girls between 13-16 yrs. old, and 64% of girls below 19 have already begun childbearing.
- Early pregnancy carries with it higher risks of maternal mortality as well as complications.
- Since girls are not expected to be informed about contraception prior to marriage, and also because of the pressure to bear the first child immediately after marriage, there is near absence of contraception in the 15-19 age group. This also means that adolescent girls run greater risks related to STIs.

HANDOUT NO: 6

Gender Issues in Abortion

INDUCED ABORTIONS

- Induced abortion is sought to terminate unwanted pregnancies resulting from non-use of spacing method of contraception because of lack of information or fear of side effects
- non-consensual sex within or outside marriage, including sexual abuse
- contraceptive failure
- male abdication of responsibility for pregnancy prevention
- 20 – 25% of maternal deaths in India are estimated to be from septic abortions
- Illegal abortions may be 11 times as prevalent as MTPs
- 2nd trimester abortions amongst highest in the world due to sex selective abortions
- MRs not generally performed but D&Cs are, which are associated with a greater probability of complications
- Access to MTP services limited by cost
- Few facilities or trained personnel
- Cumbersome licensing procedures
- Lack of privacy and confidentiality
- Providers' attitudes
- Long waiting time
- Lack of information
- Linking MTP to FP acceptance

ABORTION COMPLICATIONS

- Septic abortion
- Gangrene and tetanus
- Heamorrhage due to incomplete abortion or injury to internal organs (even D&C can cause damage to the uterine wall)
- Poisoning from abortifacients resulting in kidney failure
- Tubal infections which sometimes cause infertility

HANDOUT NO: 7

Gender Issues in CONTRACEPTION

- Contraceptive Prevalence Rate about 41% in 1992-93
- Contraception rarely practised before first birth
- Reversible methods account for less than 15% of contraceptive use.
- Male methods account for only 15%.
- Share of female sterilisation 76%
- 19.5% of women 15-49 have unmet need for contraception
- Health concerns, not having enough options, and husband's opposition feature as important reasons for non-use
- Poor reproductive health and high pregnancy loss deters use of temporary methods
- Poor quality of care an important issue: studies show sterilisation to be associated with tubal inflammation due to upper RTIs.
- Non-availability of a wide enough range of reversible methods to suit varying needs leads to abortion's use for spacing births
- Lack of male involvement a major problem
- Women contra-indicated for sterilisation often have few other contraceptive options
- Predominant reliance on sterilisation poses important challenges in an era of HIV infections: sterilised women cannot insist on condom use by their husbands, posing risk of STIs and HIV.

HANDOUT NO: 8

Gender Issues in HIV/AIDS

1. The risk of becoming infected with HIV during unprotected vaginal penetrate sex is two to four times higher for a women than man. Male to female transmission is more efficient as women have a bigger surface area of mucosa exposed to seminal fluid than does a man. More over there is higher concentration of HIV virus in semen than in the vaginal secretions of women. There is evidence that dried and fragile genital membranes and reduced vaginal secretions of post-menopausal women increase their vulnerability to HIV.

2. Most of cultural, legal and economic factors further increase risk and vulnerability. Low status of women in society, limits opportunity of education and economic activities and access to health services. This also limits opportunities to be informed about functioning of their body, control of sexuality and cripple autonomy.

3. Women are not required to discuss issues related to safe sex in specific cultural contexts or they may fear even violent reactions from partner.

4. Generally women are expected to tolerate promiscuity of men folk, even through this tolerance/silence may cost their lives.

5. Sexual violence may lead to damage to genital /anal mucosa because of lack of lubrication and rough handling by partners.

6. Prostitution constitutes a situation, when women are unusually vulnerable to HIV infection. CSWs may find hard to insist on condom use.

7. Women also face a dilemma. They may like to have a child but do not want to contact infection. They face painful choices, as use of condoms is incompatible with pregnancy.

Health Outcomes of Violence Against Women

Fatal Outcomes

- Homicide
- Suicide
- Maternal mortality
- AIDS-related

Nonfatal Outcomes

Physical Health

- Injury
- Functional impairment
- Physical symptoms
- Poor subjective health
- Permanent disability
- Severe obesity

Chronic Conditions

- Chronic pain syndromes
- Irritable bowel syndrome
- Gastrointestinal disorders
- Somatic complaints
- Fibromyalgia

Mental Health

- Post-traumatic stress Disorder (PTSD)
- Depression
- Anxiety
- Phobias/panic disorder
- Eating disorders
- Sexual dysfunction
- Low self-esteem
- Substance abuse
- Nightmares
- Affective numbing
- Autonomic arousal
- Difficulties in concentrating
- Hyper vigilance
- Heightened startle
- Memory loss

Negative Health Behaviours

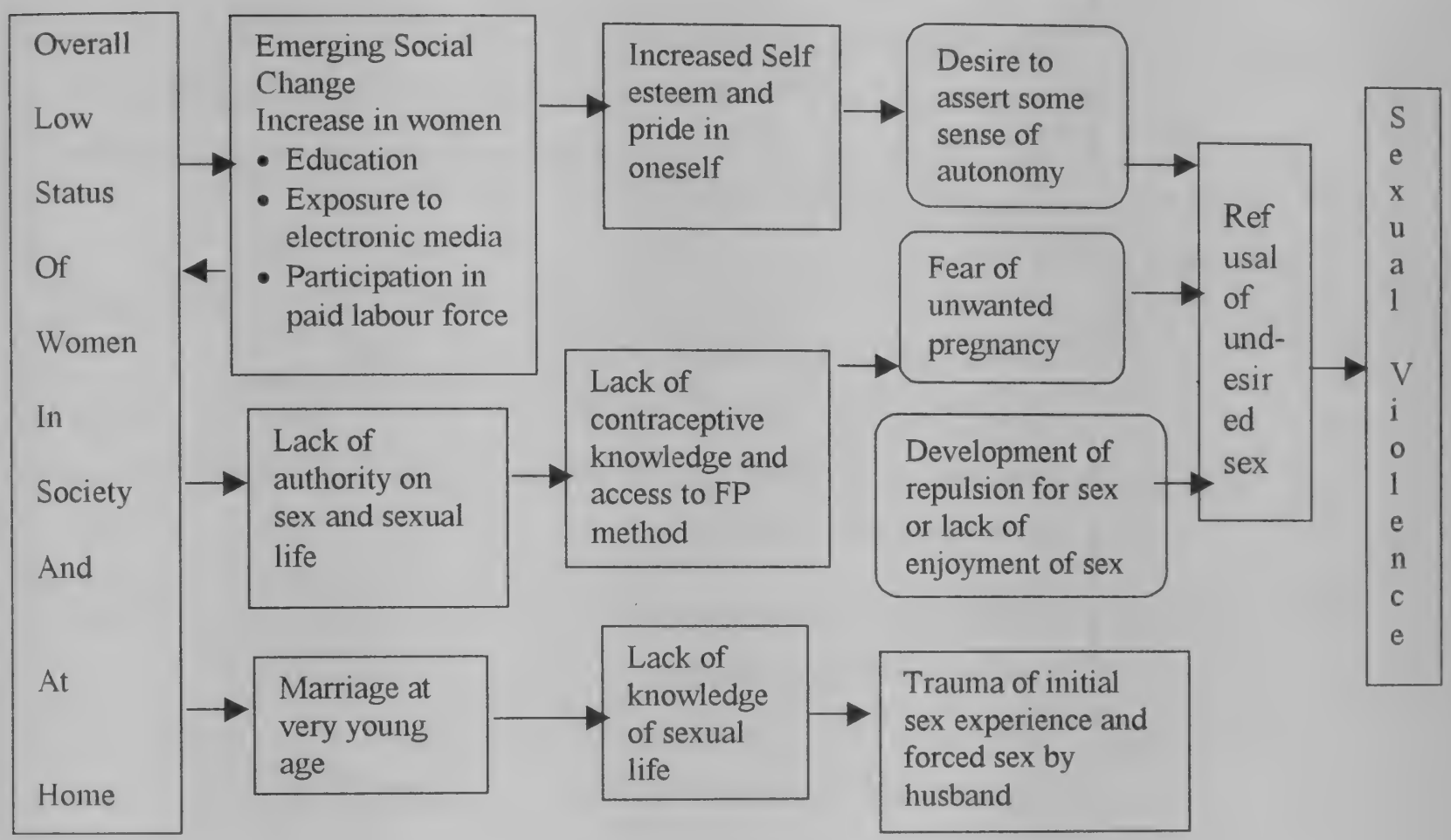
- Smoking
- Alcohol and drug abuse
- Sexual risk-taking
- Physical inactivity
- Overeating

Reproductive Health

- Unwanted pregnancy
- STDs/HIV
- Gynaecological disorders
- Unsafe abortion
- Pregnancy complications
- Miscarriage/low birth weight
- Pelvic inflammatory disease
- Vaginitis
- Colpitis

Source: Centre for Health and Gender Equity Population Reports

Dynamics of Sexual Violence within Marriage



Source: M.E. Khan et.al Sexual Violence within marriage, and case study of rural Uttar Pradesh by Cort and Population Council, New Delhi

HANDOUT NO 11

Gender Violence throughout the Life Cycle

Phase	Type of Violence Present
Prenatal	Sex-selective abortion (China, India, Republic of Korea); b attering during pregnancy (emotional and physical effects on the woman; effects on birth outcome); coerced pregnancy (for example, mass rape in war).
Infancy	Female infanticide; emotional and physical abuse; differential access to food and medical care for girl infants. Child marriage; genital mutilation; sexual abuse by family members and strangers; differential access to food and medical care; child prostitution.
Adolescence	Dating and courtship violence (acid-throwing in Bangladesh; date rape in the United States); economically-coerced sex (African schoolgirls having to take with "sugar daddies" to afford school fees); sexual abuse in the workplace, rape; sexual harassment; forced prostitution; trafficking in women.
Reproductive	Abuse of women by intimate male partners; marital rape; dowry abuse and murders; partner homicide; psychological abuse; sexual abuse in the workplace; sexual harassment; rape; abuse of women with disabilities.
Old- Age	Abuse of widows; elder abuse (in the United States, the only country where these data are now available) elder abuse mostly affects women.

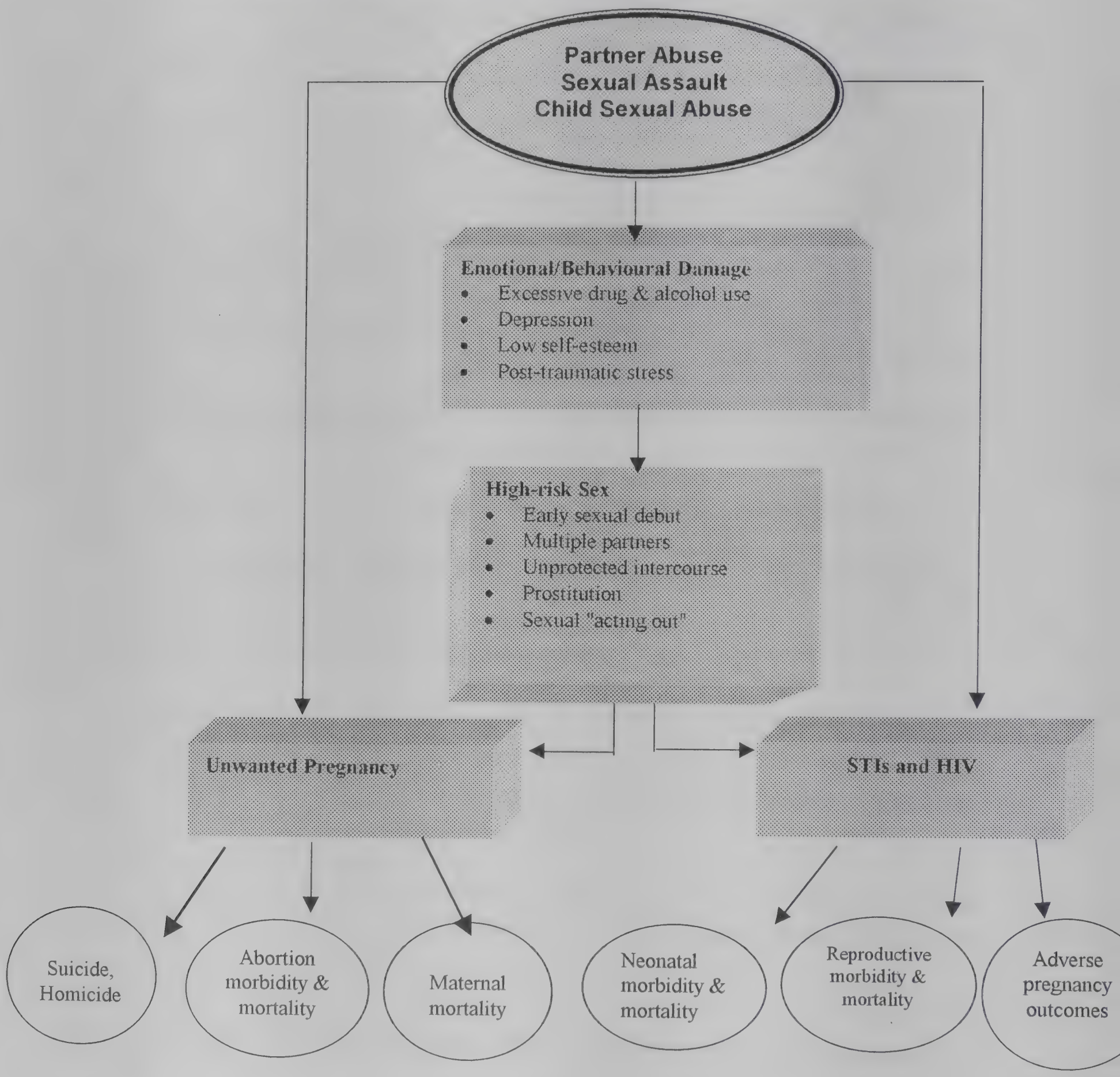
Source: L.et.al Violence again women : The Hidden Burden, World Bank Discussion Paper, 1994

Warning Signs for Health Workers

- A woman who makes an appointment but does not attend
- A woman with multiple injuries in sites that are usually covered by clothing
- A woman whose partner comes with her and stays close at hand in order to monitor what is said
- A woman with evidence of strangulation attempts on the neck or fractures to the upper arms, which may have been caused, when the women tried to defend herself.
- A woman who is excessively shy, embarrassed or anxious, or who is reluctant to provide information about how she was injured
- A woman or partner with a history of psychiatric such as depression, alcoholism, drug abuse or suicide attempts.
- A woman with a history of "accidents"
- A woman, particularly if pregnant, with injuries to the breasts, genitalia or abdomen.

HANDOUT NO: 12

VIOLENCE AGAINST WOMEN : DIRECT AND INDIRECT PATHWAYS TO UNWANTED PREGNANCY AND SEXUALLY TRANSMITTED INFECTIONS



STI = sexually transmitted infection
HIV = Human immuno deficiency virus (which causes AIDS)
Source: Adapted from Heise et al. 1995 (211)

ABUSE ASSESSMENT SCREEN

Have you ever been emotionally or physically abused by your partner or someone important to you? Yes ☐ No ☐

THIN THE LAST YEAR,
Have you been hit, slapped, kicked, or otherwise physically hurt by someone? Yes ☐ No ☐

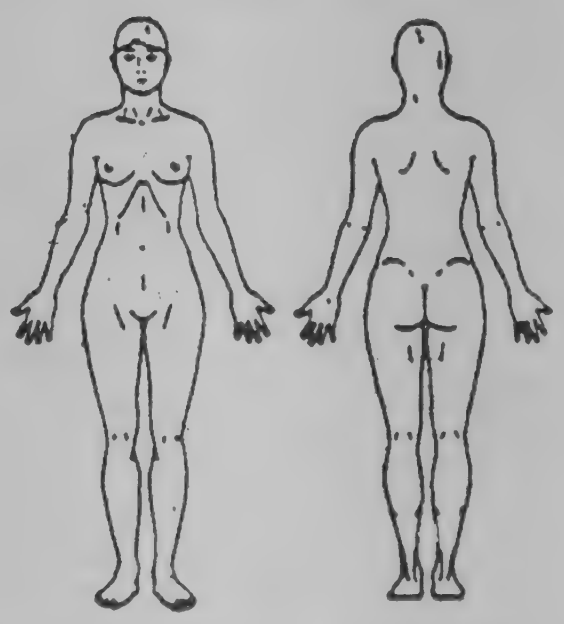
YES, by whom?_____
Total number of times _____

Once you've been pregnant, were you hit, slapped, kicked, otherwise physically hurt by someone? Yes ☐ No ☐

YES, by whom?_____
Total number of times _____

MARK THE AREA OF INJURY ON THE BODY MAP.
SCORE EACH INCIDENT ACCORDING TO THE FOLLOWING SCALE:

	SCORE
Threats of abuse including use of a weapon	_____
Slapping, pushing; no injuries and/or lasting pain	_____
Punching, kicking, bruises, cuts and/or continuing pain	_____
Beating up, severe contusions, burns, broken bones	_____
Head injury, internal injury, permanent injury	_____
Use of weapon; wound from weapon	_____



If any of the descriptions for the higher number apply, use the higher number.

WITHIN THE LAST YEAR,
Has anyone forced you to have sexual activities? Yes ☐ No ☐

YES, who? _____
Total number of times _____

Are you afraid of your partner or anyone you listed above? Yes ☐ No ☐

Source

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POPULATION MYTHS

Statement: ***India's population is growing faster than in most other countries of the world***

Explanation: **False.** Population growth rates (%)

	1951-61	1961-71	1971-81	1981-91
India	1.98	2.24	2.26	2.1
Africa	2.27	2.56	2.82	---
L.America	2.75	2.70	2.38	2.2
W. Asia	2.75	2.75	2.88	2.9
SE Asia	2.10	2.45	2.28	2.1
E Asia	1.64	2.20	1.76	1.5

June 21, 2001

POPULATION MYTHS

Statement: ***Since India's independence, population growth has overtaken food production***

Explanation: ***False.*** Since India's independence, its population has grown slightly less than 3 times, while food production has grown over 4 times.

June 21, 2001

POPULATION MYTHS

- **Per capita supplies of basic food stuffs, India** **(kg/person/year)**

	1950	1970	1995
Food grains	130	163.3	176.9
Vegetables	n.a.		74.0
Vegetable oils	3	4.1	7.1
Milk	64	33.6	60.2
Meat	6.4	6.9	9.9

- **Source: FAO 1950/51 and 1999**

June 21, 2001

POPULATION MYTHS

Food production and population growth rate (Average annual growth rate %)

Food Production		Population growth	
1951-52 to 69-70	2.7%	1951-61	1.98%
1969-70 to 80-81	2.2%	1961-71	2.24%
1980-81 to 90-91	3.4%	1971-81	2.26%

Source: CMIE and UN Demographic Year Book

June 21, 2001

POPULATION MYTHS

Statement: ***India's population is growing rapidly because couples have more children now than they did fifty years ago.***

Explanation: ***False.*** Couples in India have roughly half the number of children than they had fifty years ago.

June 21, 2001

POPULATION MYTHS

Statement: ***India's population is growing because uneducated, poor people have more children they did fifty years ago, while the educated middle class has controlled its family size in the same period.***

Explanation: ***False.*** Uneducated poor people also have half the number of children than they did fifty years ago.

June 21, 2001

POPULATION MYTHS

Statement: ***Hindus have smaller families than every other minority community***

Explanation: ***False.*** Christian and Sikhs have smaller family Sizes. The average family sizes of Hindus is 3.3, Muslims – 4.41%, Christians- 2.87% and Sikhs – 2.43% (NFHS 1992-93)

June 21, 2001

POPULATION MYTHS

Statement: ***Indian population is growing mainly because of a rapid fall in death rates since Independence***

Explanation: ***True.*** India's population is growing mainly because of better nutrition, sanitation and public health efforts. There has been no increase in birth rates.

June 21, 2001

POPULATION MYTHS

Decline in birth rate > Decline in death rate	Decline in death rate > Decline in birth rate
A.P. Haryana, HP Karnataka, Kerala, Maharashtra, Punjab, West Bengal, Tamil Nadu	Assam, Bihar, Gujarat, MP, Orissa, Rajasthan, UP

June 21, 2001

POPULATION MYTHS

Statement: ***India's cities are getting more and more crowded because of the increasing birth rate among the slim population.***

Explanation: ***False.*** Indian cities are getting more and more crowded mainly because of migration from rural areas. In fact, urban TFR has been declining more sharply than rural TFRs.

June 21, 2001

POPULATION MYTHS

Statement: ***Low population growth is the first step towards economic progress.***

Explanation: **Can't say.** The relationship between economic progress and population growth is a complex one. There is no direct cause and effect relationship.

June 21, 2001

POPULATION MYTHS

	TFR Per capita SDP SRS 95-97		% below 93-94) poverty line
AP	5	11	14
Assam	7	7	4
Bihar	11	15	1
Gujarat	6	6	13
Haryana	8	3	12
Karnataka	3	5	9
Kerala	1	9	11
MP	9	12	3
Maharashtra	5	2	6
Orissa	6	14	2
Punjab	5	1	15
Rajasthan	10	11	10
Tamil Nadu	2	4	9
Uttar Pradesh	12	13	5
West Bengal	4	9	7

POPULATION MYTHS

Statement: ***Population density is inversely related to economic progress.***

Explanation: Madhya Pradesh has a very low population density, but its per capita income is not among the highest. Netherlands and Japan have higher population densities than ours, but they are rich developed countries.

POPULATION MYTHS

Statement: ***Women are more likely to be adversely affected by the two child norms than men.***

Explanation: Can't say. For women in good health and not in a context of gender discrimination, two child norm would be beneficial and contribute to their well-being. Unfortunately, a very large number of women are not in such a position.

POPULATION MYTHS

For women who are in poor health, live in a family context of son preference, and have to take sole responsibility for contraception, a strong desire to limit family size could mean taking many health risks. Abortions, including sex- selective, undergoing sterilization despite poor health, and coping with psychological distress especially if she does not have a male child. This could include threat of desertion or neglect.

POPULATION MYTHS

Statement: ***While 90% of the global population growth occurs in developing countries, more than 70% of the world's resources are consumed by less than 20% of the population living in the affluent Western countries.***

Explanation: ***True.*** There is a similar difference in consumption between the affluent and poor within countries. It is often the small well-off section of the population who consume a lion's share of the resources.

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